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In The

Supreme Court of the United States

October Term, 1984

SEBASTIAN REBALDO, as Chairperson of the Board of Trustees of the UNITED OPTICAL WORKERS INSURANCE FUND,

Petitioner,

vs.

MARIO CUOMO, GOVERNOR OF THE STATE OF NEW YORK; and DAVID AXELROD, COMMISSIONER OF HEALTH OF THE STATE OF NEW YORK,

Respondents.

PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SECOND CIRCUIT

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QUESTION PRESENTED

Whether a state statute that prohibits the continuation or negotiation of discount rate agreements between self-insured employee benefit plans and hospitals, while mandating discount rates for state regulated not-for-profit health insurance corporations, "relates to" an employee benefit plan within the meaning of Section 514(a) of the Employee Retirement Income Security Act of 1974, 29 U.S.C. §1144(a) and is therefore pre-empted by that Act.*

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* The caption of the case in this Court contains the names of all parties in the United States Court of Appeals for the Second Circuit. Blue Cross and Blue Shield of Greater New York ("Blue Cross") and the Hospital Association of New York participated in the court below as *Amici Curiae* in support of respondents.

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OPINIONS BELOW

The November 26, 1984 opinion of the United States Court of Appeals for the Second Circuit is reported at 749 F.2d 133 and is reprinted at Appendix ("App".) 1-16 to this petition. The March 12, 1984 opinion of the United States District Court for the Southern District of New York is not officially reported and is reprinted at App. 17-43 to this petition.

JURISDICTION

The judgment of the United States Court of Appeals for the Second Circuit was entered on November 26, 1984. This Court has jurisdiction pursuant to 28 U.S.C. §1254(1).

CONSTITUTIONAL AND STATUTORY PROVISIONS INVOLVED

Relevant portions of Section 514 of the Employee Retirement Income Security Act of 1974, as amended, ("ERISA"), 29 U.S.C. §1144 and Section 2807-a.6(b) of New York Public Health Law (McKinney Supp. 1984-1985), are reprinted at App. 49-52 to this petition.

STATEMENT OF THE CASE

This case involves the extent to which a State may, through regulation, influence the form and operation of employee benefit plans. The issues presented are related closely to those before the Court in *Metropolitan Life Insurance Company v. Commonwealth of Massachusetts*, No. 84-325, *argument scheduled*.

Petitioner is the Chairperson of the Board of Trustees of a small self-administered employee welfare benefit plan[1] ("the Fund") that provides health, hospitalization and other benefits to approximately 1500 employees and their dependents. The Fund's participant work for 180 contributing employers located in five states: New York, New Jersey, Connecticut, Massachusetts and Florida.[2]

The employee participants in the Fund receive modest salaries. Without the benefits provided by the Fund, these participants would be "medically indigent" because they could not afford to purchase health insurance from Blue Cross and other commercial insurers, yet they earn too much to qualify for federal medical assistance under Medicaid. But for the Fund, hospitals that provide care to this group would often be unable to collect their fees. By providing hospital coverage to groups otherwise medically indigent, the Fund serves an important public interest.

The Fund provides benefits to its participants and their dependents regardless of past medical experience or health risk.

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1. Section 3(1) of ERISA, 29 U.S.C. §1002(1), defines an "employee welfare benefit plan", in part, as one that is "established or is maintained for the purpose of providing for its participants or their beneficiaries, through the purchase of insurance or otherwise, (A) medical, surgical or hospital care or benefits." Section 3(3) of ERISA, 29 U.S.C. §1002(3), defines the terms "employee benefit plan" and "plan" to mean either an employee welfare benefit plan or an employee pension benefit plan. As used herein the terms "ERISA fund" and "plan" mean an employee welfare benefit plan.

2. The facts as set forth were contained in the complaint and papers submitted in the district court in support of a motion for a preliminary injunction. At the suggestion of the district court the parties and amicus curiae Blue Cross agreed to treat the motion as one for summary judgment on the issue of pre-emption under ERISA and further agreed that there were no material facts in dispute. Accordingly, for the purposes of this petition, the material facts as asserted by the Fund must be deemed uncontested.

It is the primary provider under Medicare for workers aged 65-69, who are entitled to the same benefits offered under the plan to younger workers. The Fund also provides benefits for pensioners and laid off employees. Benefits are provided to all participants without reference to their income or the rate at which each member's employer contributes.

The Fund's primary source of funding consists of the contributions made by employers pursuant to collective bargaining agreements with United Optical Workers Local 408, IUE, AFL-CIO ("Union"). Those agreements fix the rate of contributions for a period of three years, the duration of the contracts. Because of depressed economic conditions in the optical industry during the past few years, the Union experienced great difficulty in negotiating increases in Fund contributions. At the same time, the cost of providing benefits to the participants increased dramatically. As a result, the Fund suffered serious losses in its assets since 1980. Among the major escalating costs faced by the Fund prior to 1983, were the charges to the Fund for Blue Cross hospitalization coverage.

In 1982, in order to reduce losses and enable the Fund to keep the hospitalization benefits for its members intact, the trustees of the Fund decided to end its relationship with Blue Cross effective January 1, 1983. Instead of insuring with Blue Cross, the Fund became self-insured and continued to provide the same hospital benefits previously provided under contracts with Blue Cross. ERISA leaves the decision of whether to insure or self-insure a welfare plan to the discretion of the trustees. Section 3(1) of ERISA states that a welfare plan may be maintained "through the purchase of insurance or otherwise". Accordingly, so long as the trustees are acting "for the exclusive purpose of (i) providing benefits to participants and their beneficiaries; and (ii) defraying reasonable expenses of administering the plan", Section 404 of ERISA, 29 U.S.C. §1104, the decision about how to structure the plan is theirs to make. Here, after careful review of the

alternatives, the trustees concluded they could best provide benefits and conserve fund assets by turning to self-insurance.

Self-insurance represented a major step toward defraying expenses and conserving assets, primarily because the Fund was able to negotiate directly with hospitals for hospital charges. Through its agent, the Fund obtained agreements with over 100 area hospitals, calling for charges at rates 5% above the rate paid by Blue Cross. Coupled with more effective claim and billing practice review, increased administrative efficiency and the cash flow benefit derived from paying claims rather than insurance premiums (which require a 3 to 4 month reserve account) during the first 8 months of 1983 under self-insurance, the Fund reaped substantial savings. The Fund's actuary projected that for the first 12 months under self-insurance the Fund would save approximately $120,000, without reduction of benefits.

The State Statute at Issue

New York Public Health Law Section 2807-a.6(b) went into effect on January 1, 1984. As of that date, all discount agreements between self-insured ERISA funds and hospitals governing in-patient hospital charges were prohibited. In place of the outlawed agreements, the statute compels ERISA funds to reimburse hospitals for services rendered to their members at mandatory rates set at 12-15% above those charged to subscribers of not-for-profit health insurance companies incorporated under Article 9-C of the New York Insurance Law, of which Blue Cross is by far the largest. Hospitals are directed to grant the mandatory discounts to Blue Cross and are prohibited from accepting less than the statutory maximum from employee benefit plans. A statutory exception was created for employee benefit plans with discount contracts in effect on May 1, 1982, permitting them to continue. Thus, not only did the legislature consider ERISA plans when it enacted the statute, the State actually created separate

classes of ERISA plans by carving out an exemption for plans with contracts in existence before May, 1982.

The opinion below implies that a finding of pre-emption would endanger a state interest. While such considerations are irrelevant under ERISA, the fact is that pre-emption of the provision of the statute relating to ERISA plans would have no discernible impact on the goal of containing hospital costs.[3]

The Proceedings in the District Court

Although pre-emption would have no impact on the State's cost containment goals, the impact of the statute on self-insured employee benefit plans would be devastating. For petitioner, who had recently left Blue Cross and turned to self-insurance as a means of minimizing expenses and preserving benefits in the face of serious financial problems, the loss of its discount agreements with hospitals spelled financial disaster. Without the ability to continue to pay hospitals for services provided to Fund members at rates competitive with those provided to subscribers of Blue Cross, the Fund would have to reduce benefits, forego self-insurance and return to Blue Cross.

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3. The Deputy Director of the Office of Health Systems Management conceded that at the time Section 2807-a.6(b) was enacted, the State was unaware of the "nature and extent of [self-insured ERISA fund] discount charges agreements." Joint Appendix ("J.A.") filed in the Second Circuit at 391. Thus, it was also unaware of the number of agreements preserved by the provisions exempting discount agreements entered into prior to May 1, 1982. By the State's own admission, the exemption for plans with contracts in effect in 1982 could have preserved 99.9% of ERISA fund contracts and outlawed only .1% of such contracts. In fact, in opposition to the State's motion for a stay pending appeal, the Fund disclosed that the number of self-insured ERISA funds whose contracts were abrogated by this statute accounted for under 1% of total hospital in-patient revenues. Hence, pre-emption of the offending provision could make no appreciable difference on the statute's effectiveness. Rather, as shown in

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Because the state statute posed a serious threat to the structure, operation and plan of benefits provided by the Fund, it commenced this suit for injunctive and declaratory relief, alleging pre-emption under Section 514(a) of ERISA, 29 U.S.C. §1144(a). That section provides in relevant part:

> ". . . the provisions of this subchapter and subchapter III of this chapter shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan described in section 1003(a) of this title and not exempt under section 1003(b) of this title . . . ."

The Fund moved for a preliminary injunction in the district court.[4] That motion was converted with the consent of the parties to a motion for summary judgment on the question of pre-emption under ERISA. In opposition, the State and amicus Blue Cross conceded that the statute regulated and related to ERISA funds, but argued that it was saved from pre-emption by the exception

(Cont'd)

the district court, its inclusion in the statute was the apparent result of a successful lobbying effort by Blue Cross to put an end to self-insured and self-administered employee benefit plans in New York State. The State itself conceded that one of the goals of the legislation was: "Keeping Blue Cross competitive in the marketplace." (Appellant's Memorandum in Support of Motion for a Stay Pending Appeal filed in the Second Circuit at p. 17). In seeking a stay from the district court judgment the State also admitted that one of the perceived "danger[s]" of that judgment was: "the possibility that the March 30 judgment will encourage large numbers of currently non self-insured ERISA funds to become self-insured." (J.A. 391).

4. The Fund also claimed that the statute violates the antitrust laws, the commerce, contracts and supremacy clauses of the United States Constitution and the Equal Protection Clause of the Fourteenth Amendment. The basis for federal jurisdiction in the district court was Section 502 of ERISA, 29 U.S.C. §1132; 28 U.S.C. §1331(a); 28 U.S.C. §1337 and 15 U.S.C. §15.

for laws regulating insurance (Section 514(b)(2)) (App. 50), and by Section 514(d) (App. 51), which preserves federal laws from ERISA pre-emption.

Neither the State nor Blue Cross ever suggested in the district court that the state statute does not "relate to" ERISA funds. As the district court found:

> "Neither defendants nor *amicus* argues that §2807-a.6(b) does not relate to ERISA plans, and such an argument would not prevail. Section 2807-a.6(b) adversely affects the administration of such plans in at least two ways. It is obvious that if the Fund is required to pay the higher reimbursement rates set for charge payors, it will not be able to provide the same breadth of coverage for its beneficiaries. Its other alternative is to return to the previous arrangement of purchasing insurance through Blue Cross, but the Fund asserts that its experience has shown this arrangement to still be more expensive than the present system, and that some reduction in benefits would still be necessary to cover increased costs.
>
> In addition, by imposing a local condition on the administration of covered funds, §2807-a.6(b) runs afoul of ERISA's goal of facilitating the operation of uniform multi-state plans. In order to best conserve assets, the Fund might well find it practical to operate separate plans in different states; it might find that it could provide benefits most efficiently by insuring through Blue Cross in New York and by self-insuring in states without similar restrictions. This would result in higher administrative costs, and, as the Supreme Court noted in *Shaw*, would eventually necessitate a decrease in benefits.

> It should be noted, as well, that §2807-a.6(b)'s impact on ERISA plans is not incidental; it is apparent from the express exclusion of discount contracts entered into by 'self insured and self-administered groups' before May 1, 1982 that the legislature considered ERISA plans and fully intended to curtail their ability to negotiate or receive discounts after January 1, 1984. This conclusion is further supported by direct references to 'self-insured groups [that] have negotiated payment rates with individual hospitals' in a report by the statutorily-created Council on Health Care Financing, which was charged with devising a plan for financing hospital inpatient care, and also by statements attributed to Edwin Werner, the President of Blue Cross and a member of the Council on Health Care Financing.
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> * * *
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> I am convinced, based upon the foregoing, that §2807 a.6(b) 'pertains to' and 'refers to' ERISA funds, and that it has a direct 'bearing on' and 'connection with them.' " (App. 25-27).

The Proceedings and Opinion Below

On appeal, the State for the first time claimed that the statute did not "relate to" ERISA funds. Although not argued at the district court level, the Court of Appeals determined to entertain the argument noting the "broad legal ramifications" of the decision in this case (App. 8).

In urging affirmance of the district court's opinion, the Fund pointed out that the obvious and conceded purpose of the state

law to regulate employee benefit plans was dispositive.[5] However, the Fund also discussed at length the *impact* of the statute as further evidence that it "relates to" employee benefit plans. The Fund showed that:

> 1. The state law impermissably interfered with the right of employee benefit plans to be structured and operate through self-insurance;
>
> 2. The statute imposed an onerous economic burden on self-insured employee benefit plans that would force the Fund to reduce benefits; and
>
> 3. The statute undermined the Fund's ability to maintain uniform interstate administration.

Acting under the erroneous premise that it should rule against pre-emption unless an opposite result was "unavoidable" (App. 11), the court below held that the state law did not "relate to" ERISA funds. It reached its conclusion in reliance on footnote 21 of this Court's opinion in *Shaw v. Delta Air Lines*, 462 U.S. ____, ____ n.21, 103 S.Ct. 2890, 2901 n.21 (1983), regarding state actions that affect employee benefit plans "in too tenuous, remote or peripheral a manner to warrant a finding that the law 'relates to' the plan".

The opinion made no mention of petitioner's claims and the district court's findings with respect to the clear purpose and effect of the state law to regulate and curtail the rights and activities of employee benefit plans and discourage self-insurance. Although the court held (App. 9) that the phrase "relate to" under Section

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5. The Fund noted other legislative history in addition to that which was cited by the district court in which the State's purpose to regulate ERISA plans was disclosed. (See J.A. 162 No. 11, 141 No. 2).

514(a) was limited to actions which regulate the "terms and conditions" of an employee benefit plan (ERISA Section 514(c)(2)),[6] it failed to consider whether the statute regulated any "terms and conditions" of employee benefit plans.[7]

The Second Circuit predicated its decision on its conclusion that contracts or arrangements for the provision of hospital care are merely incidental aspects of the plan's "cost of doing business", no different from "rent control laws" or "bridge and tunnel tolls" (App. 12).[8] But, the sole function and purpose an employee welfare benefit plan is to provide hospital care or benefits. 29 U.S.C. §1002(1). Contracts fixing the terms governing the cost of those benefits are not remote or peripheral but rather

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6. 29 U.S.C. §1144(c)(2). That section defines the term "State" following the definition of "State Law" as follows: "The term 'state' includes a State, any political subdivisions thereof, or any agency or instrumentality of either, which purports to regulate, directly or indirectly, the terms and conditions of employee benefit plans covered by this subchapter."

7. The Fund pointed out that *Shaw* interpreted the phrase "relate to" without any reference to the phrase "terms and conditions" contained in Section 514(c)(2) presumably because there, as here, it was not disputed that the law in question was the enactment of a "State". The Fund also cited H.R. Rep. No. 1785, 94th Cong. 2d. Sess. 47-48 (1977) (a report cited by this Court in *Shaw*, 103 S.Ct. at 2901 n.20), for the view that the phrase "terms and conditions" was not intended "to limit the preemptive effect of Section 514(a)." That report concluded that "the phrase 'terms and conditions' . . . has a very broad scope . . ." and that "any activity by a state or political subdivision thereof, which relates to employee benefit plans, *qua* benefit plans, is preempted by Section 514(a)."

8. If a state rent control law outlawed all leases entered into between employee benefit plans and landlords and directed that plans pay rent at rates 15% higher than that charged to state regulated health insurance companies, the law would "relate to" ERISA funds within the meaning of Section 514(a). Like the statute here, any regulation directed specifically at ERISA plans would *per se* "relate to" such plans.

have a direct and substantial impact on the basic operation and structure of such plans. A statute abrogating the Fund's contracts and mandating that employee benefit plans pay the maximum hospital charges permitted, is hardly analogous to the "tangential" laws cited by the court below, i.e., those incidentally affecting some individual employees, garnishment of pension benefits to collect child support, etc.

This statute is also quite different from the human rights law considered by the Ninth Circuit in *Lane v. Goren* (No. 83-6496 Sept. 27, 1984), decided after oral argument in the court below and cited twice in the court's opinion (App. 10, 11-12). The ban on racial discrimination in that statute did not in any way purport to regulate employee benefit plans *qua* employee benefit plans. Nor was that the intent of the California legislature. Moreover, the prohibition against a fund's treatment of its employees in a racially discriminatory manner affected no essential purpose or function of the fund.

In ruling that the instant statute survived ERISA pre-emption, the Second Circuit misconstrued the decisions of this Court, employed an analysis of pre-emption inappropriate under ERISA and opened the floodgates to precisely the kind of patchwork and conflicting state legislative enactments that ERISA's broad pre-emption provision was designed to prevent.

REASONS FOR GRANTING THE WRIT

I.

This case involves important questions of federal law presently under consideration by this Court.

This case involves important federal questions affecting the structure and operation of employee benefit plans that parallel closely those the Court has undertaken to consider in *Metropolitan*

Life Insurance Company v. Commonwealth of Massachusetts, No. 84-325. In both cases, state statutes designed with employee benefit plans in mind, have survived pre-emption challenges, by an expansive interpretation of the exceptions to pre-emption. In both cases the courts have employed an analysis that is inappropriate in view of the explicit pre-emption provision contained in ERISA, its legislative history, and this Court's determination that Congress intended to achieve the broadest possible ouster of state action in the employee benefit plan area.

Considered together, these cases highlight how state action can erode ERISA's goals of promoting the growth, financial soundness and opportunity for uniform multistate administration of employee benefit funds.[9] The statute before the Court in *Metropolitan* purports to confine its regulatory impact to those funds purchasing insurance. The lower court there eliminated the requirement that self-insured ERISA funds provide certain benefits required of insurance companies. Therefore, to avoid the restrictions imposed by the statute, employee benefit plans in Massachusetts must self-insure. In contrast, the statute at issue here operates as a dis-incentive to self-insurance by employee benefit plans. Although the statute does not directly forbid self-insurance or compel plans to insure through Blue Cross, that is its clear effect.[10]

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9. In fact, the New York statute's requirement that Funds pay the maximum rates chargeable by hospitals will have a more devastating impact on ERISA funds than could the Massachusetts mandated benefit statute. The New York statute requires this Fund to pay at least 10% more for all hospital services than it is obliged to pay under its discount contracts prohibited by the state law. The increased expense for the mental health coverage at issue in *Metropolitan* is slight by comparison.

10. The impact of the conflicting state pressures on this Fund are startling. This Fund has employees and benefit programs in both New York and Massachusetts. It is pressured to self-insure in Massachusetts and to abandon

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Because of the similarity of issues raised by the two cases, the Court's decision in *Metropolitan* will affect the judgment in this case. If this Court adopts the analysis of pre-emption advocated by the appellants in *Metropolitan*,[11] it will rule that laws that have the effect of regulating ERISA plans must be pre-empted regardless of whether they also purport to regulate insurance. In that event, the Second Circuit will have decided a federal question in a way in conflict with a decision of this Court. In any event, consideration of this case along with *Metropolitan* will enable the Court to provide needed guidelines for the lower courts in applying the pre-emption provision of ERISA.

Moreover, this case presents important federal questions that go beyond the issues in *Metropolitan*. The decision below permits a state with an acknowledged purpose and intention to regulate employee benefit plans, to do so. It permits a state to restrain the growth and financial soundness of self-insured employee benefit plans because of some perceived state benefit in enhancing the competitive status of Blue Cross. However, Congress made clear that the decision of whether to fund and administer a plan

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self-insurance in New York. Adapting to the conflicting requirements of the two statutes becomes virtually impossible under a uniform system of administration. Even without the contradictory pressures of the Massachusetts law, maintenance of self-insurance in the other states obviously will be more expensive administratively if the Fund must forego self-insurance in New York. A reversion to Blue Cross in order to take advantage of its statutory discount, would require the Fund to relinquish control over the administration of claims in New York. Premiums the Fund would be charged by Blue Cross would include payment to the insurance company to administer those claims. Retention of Fund personnel solely to administer the self-insured claims in other states would obviously be less cost-effective and, depending on the ratio of such claims to New York claims, might require abandonment of self-insurance on a multi-state basis altogether.

11. Brief for appellant in *Metropolitan*, p. 34, 35.

through insurance or self-insurance was a matter left to the discretion of the fiduciaries administering the plans. The trustees of the Fund are charged under ERISA to act solely in the best interests of the participants and beneficiaries and for the "exclusive purpose of providing benefits" and "defraying reasonable expenses, of administering the plan." ERISA Section 404(a)(1)(A), 29 U.S.C. §1104 (a)(1)(A). They are obliged therefore to provide the maximum benefits to the participants at the least possible expense. The New York statute interferes directly with the duties of the trustees. In so doing it effectively forecloses a method of plan operation expressly permitted by Congress.

The Fund does not dispute that rising hospital costs are a matter of national concern.[12] Indeed, the Fund has been in the forefront of efforts to control hospital costs by undertaking stringent billing practice and claim review following its conversion to self-insurance. The opinion below was, in effect, based on the court's view of the importance of the state law. The court implicitly balanced the goals of the State against the Fund's rights under ERISA. Yet, however attractive state efforts to control hospital costs may appear, absent amendment by Congress, regulation under the guise of cost containment in the health care field should not be permitted to thwart the clear mandate of ERISA to pre-empt state laws relating to employee benefit plans.

The ruling below was inappropriate and unless reviewed will serve as authority for further significant erosion of pre-emption.

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12. Obviously the Fund does not contend that all state hospital cost containment efforts are pre-empted. Concededly, there are many state laws controlling hospital costs that do not run afoul of the pre-emption provision.

II.

The decision below is in conflict with decisions of this Court and with the decisions of other federal courts of appeals.

There is no room after *Shaw* for an analysis which precludes a finding of preemption under ERISA unless a contrary conclusion is "unavoidable." In fact, the opposite is the case. This Court held that "Congress used the words 'relate to' in §514(a) in their broad sense", *Shaw* at 2900, "creating only very limited exceptions to pre-emption." *Shaw* at 2903. Hence, it was the duty of the court below to apply the term expansively rather than in the strained and narrow manner that it did.

Rulings calling for pre-emption of state law in the health care field prevailed even prior to *Shaw*. Thus this Court affirmed summarily the Ninth Circuit's holding in *Standard Oil of California v. Agsulud*, 633 F.2d 760, 766 (9th Cir. 1980), *aff'd mem.*, 454 U.S. 801 (1981), that the Hawaii Pre-Paid Health Care Act was pre-empted by ERISA. The Ninth Circuit explicitly took "a broad view of the pre-emption of federal law over state law in the health insurance field . . . ." The court in *Agsulud* specifically endorsed Judge Renfrew's pertinent comments that: "ERISA shall supersede any and all state laws and that does not mean 'some but not all state laws.' " 633 F. 2d at 765, *citing* 442 F. Supp. 655 at 707 (N.D. Cal. 1977). Judge Renfrew also had remarked: "[t]o hold that a state health insurance law does not regulate directly or indirectly the terms and conditions of employee benefit plans would distort the meaning of those words beyond recognition." *Id.* Similarly, the opinion in *Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504, 524 (1981), noted that although the workers compensation awards there were "obviously . . . subject to the State's police power," even indirect interference with an employee benefit plan could not escape pre-emption:

> "It is of no moment that New Jersey intrudes indirectly through a workers compensation law, rather than directly through a statute called 'pension regulation.' ERISA makes clear that even indirect state action bearing on private pensions may encroach upon the area of exclusive federal concern . . . ERISA's authors clearly meant to preclude the States from avoiding through form the substance of the pre-emption provision." 451 U.S. at 525.

The decision below is also in conflict with the Ninth Circuit's decision in *Hewlett-Packard Company v. Barnes*, 571 F. 2d 502 (9th Cir. 1978), *cert. denied*, 429 U.S. 831 (1979). There, the court ruled that an analogous California statute regulating health maintenance organizations[13] was pre-empted to the extent it applied to employee benefit plans. The Ninth Circuit again adopted (571 F. 2d at 504) the reasoning of Judge Renfrew who held:

> "Effective since July 1, 1976, Knox-Keene governs the delivery of health care services to California residents who participate in health care service plans. In enacting Knox Keene, the California legislature intended to promote the delivery of low cost, quality health care through financially sound plans to participants well informed of the benefits of various available plans.
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> Although defendant finds the phrase 'relate to' 'vague and ambiguous,' the Court doubts that

13. The statute here grants mandatory discounts to health maintenance organizations as well.

> Congress could have chosen any more precise language to express its intent to preempt a state statute such as Knox-Keene insofar as it seeks to regulate ERISA-covered employee benefit plans such as those maintained by plaintiffs." 425 F. Supp. 1294, 1297 (N.D. Cal 1977). (Footnote omitted).

As this Court noted recently in *Brown v. Hotel and Restaurant Employees Local 54*, 104 S.Ct. 3179, 3185 (1984):

> "When federal pre-emption is invoked under the directive of the Supremacy Clause, it falls to this Court to examine the presumed intent of Congress. See *Fidelity Federal Savings & Loan Assn. v. De La Cuesta*, 458 U.S. 141, 152-153 (1982). Our task is quite simple if, in the federal enactment, Congress has explicitly mandated the pre-emption of state law, *see Shaw v. Delta Air Lines* . . ."

Having reviewed the analysis applied by the courts in Section 514 cases, one commentator stated:

> "The goal of an express pre-emption analysis... should be to prevent subtle or incremental state encroachment into a field that Congress has chosen expressly to reserve for federal law. Yet, courts have mistakenly applied pre-emption doctrines fashioned in implied pre-emption cases to section 514 cases, in which the issue is whether the federal law — by its express terms — pre-empts the state law in question. Once Congress has declared its express intent to pre-empt or to save a state law, it has largely obviated judicial inquiry into considerations other than those concerning the text

> of the pre-emption provision." Kilberg and Inman, *Preemption of State Laws Relating to Employee Benefit Plans: An Analysis of ERISA Section 514* ("Kilberg") 62 Texas L.R. 1313, 1316 (1984).

Criticizing the same kind of analysis as that employed by the Second Circuit here, *Kilberg* continued:

> "The first approach, which calibrates the extent of ERISA pre-emption to reflect the importance of the relevant state law, contravenes Congress' unmistakable intent. Congress sought to pre-empt all state laws that relate to employee benefit plans except for those it exempted specifically. Neither marital property laws, nor antidiscrimination laws, nor any other state laws that courts have found to merit special scrutiny are on the statutory list. Once Congess has decided to disrupt the federal-state balance to a given degree, the courts have no legitimate basis for reweighting that balance. To focus on the traditional role of the state in a particular field or the importance of a given law to the state is to circumvent the analysis of whether the law in question relates to employee benefit plans within the meaning of Section 514(a)." 62 Texas L.R. at 1326 (Footnotes omitted).

The only *narrow* reading of ERISA pre-emption permitted under *Shaw* respects the scope of the *exceptions* to pre-emption, not the other way around. The opinion below permits the exceptions to pre-emption under ERISA to swallow the rule and distorts the meaning of Section 514(a) beyond recognition.

Even if the narrow standard employed below could somehow be reconciled with the cited opinions, the lower court's actual

treatment of the statute's relation to employee benefit plans was entirely inadequate. The Second Circuit implied that preemption is limited to those State laws requiring or prohibiting benefits (App. 11).[14] That is not the case. In *Agsalud,* the opposite argument was made by the State of Hawaii, namely, that ERISA pre-empts only state laws dealing with plan administration and exempts all laws dealing with benefits. This Court affirmed the opinion of the Ninth Circuit which noted: "There is, however, nothing in the statute to support such a distinction between the state laws relating to benefits as opposed to administration." 633 F. 2d 760 at 765.

In an analogous situation involving legal services plans, Senator Javits, one of the leading sponsors of ERISA, emphasized that pre-emption could not be avoided by indirect state action regulating form rather than content:

> "the State, directly or indirectly through the bar, is pre-empted from regulating the form and content of a legal service plan, for example, open versus closed panels, in the guise of disciplinary or ethical rules or proceedings." 120 Cong. Rec. 29,948-49 (1974).

Similarly, "in the guise" of regulating hospital costs, the State may not affect the self-insured as against the insured "form" of an employee benefit plan.

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14. The statement below that the statute did not affect the structure, administration or type of benefits provided (App. 12) completely ignores the uncontested facts. As the matter of the statute's "relation to" ERISA funds was never litigated in the district court, the Second Circuit was bound to accept the Fund's contentions as true. It was certainly not free to ignore the record or make implied factual findings contrary to the record on an issue never raised in the trial court.

Equally unacceptable under *Shaw* was the Second Circuit's reliance on the purported "general" character of the state law (App. 12 and n.2). *Shaw* specifically emphasized that the generality of the law was irrelevant under Section 514(a): "It would have been unnecessary to exempt generally applicable state criminal statutes from pre-emption under §514(b), for example, if §514(a) applied only to state laws dealing specifically with ERISA plans." 103 S.Ct. at 2900.[15]

The Second Circuit concluded that the state law's effect on employee benefit plans was peripheral, apparently because it found that the statute's economic impact was indirect (App. 12). However, the equation of "peripheral" with "indirect" runs afoul of the express language of ERISA and ignores a wealth of judicial authority that has interpreted it.[16]

It has long been recognized that the power to impose costs is the equivalent of the "power to destroy [and] that the power to destroy may defeat and render useless the power to create."

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15. *See Pervel Industries Inc. v. Connecticut Commission on Human Rights and Opportunities*, 468 F. Supp. 490, 492 (D.Conn. 1978), *aff'd mem.*, 603 F.2d 214 (2nd Cir. 1979), *cert. denied*, 443 U.S. 1031 (1980); *Baker v. Caravan Moving Corporation*, 561 F. Supp. 337 (N.D. Ill. 1983); *National Carriers' Conference Committee v. Heffernan*, 454 F. Supp. 914 (D. Conn. 1978).

16. In noting that some state actions may affect employee benefit plans so peripherally that they do not relate to them, the *Shaw* opinion cited *American Telephone Company v. Merry*, 592 F. 2d 118 (2nd Cir. 1979), as illustrative. That case premised its holding on the theory enunciated in *Stone v. Stone*, 450 F. Supp. 919, 924 (N.D.Cal. 1978), *aff'd*, 632 F.2d 740 (9th Cir. 1980), *cert. denied sub nom., Seafarers Int'l Union v. Stone*, 453 U.S. 922 (1981), that ERISA should not be construed as infringing *sub silentio* "the power to make rules to establish, protect and strengthen family life . . .", and a similar statement by Judge Weinfeld in *Cartledge v. Miller*, 457 F. Supp. 1146, 1154 (S.D.N.Y. 1978), finding that no inference should be made "that Congress meant to preclude the *ancient* family law right of maintenance and support and the issuance of process to enforce that right."

(Cont'd)

M'Culloch v. Maryland, 14 U.S. (4 Wheat.) 431 (1819). Surely, Congress did not intend that through a law regulating hospital reimbursement methods States could place an economic stranglehold on the very plans they were forbidden to regulate.

Merely because a state law has an indirect economic impact on an employee benefit fund does not render it peripheral. Where as here, the State is regulating the purchase of health care, the very business of the Fund, it cannot be said that such regulation is peripheral and therefore does not "relate to any employee benefit plan".

This and other courts have been careful to scrutinize state action, however categorized, which impacts on employee benefit plans, to prevent by indirection as well as by direct action, erosion of the pre-emption mandated by Congress. *Alessi* involved a state law prohibiting certain offsets in pension benefits. This Court's opinion reviewed carefully Congress' goal of containing costs of employee plans and quoted extensively from reports expressing concern over practices that would increase the costs of providing pension benefits. 451 U.S. 514-516. Likewise, *Shaw* acknowledged that pre-emption of a state law requiring the provision of pregnancy benefits, furthered Congress' desire to prohibit state laws that would increase plan expenses. 103 S.Ct. 2904 n.25. Closely analagous to the type of economic impact of the statute here is that involved in the state tax law considered in *National*

(Cont'd)

The distinctions between this case and the marital support cases are self-evident. A marital support order affects a single individual and has no impact on a plan's ability to fulfill its basic statutory purpose. The legislation at hand deals with the lifeblood of the plan and affects the purpose for which it exists.

Similar attempts by states to analogize to the *Merry* line of cases have been rejected. *Stone & Webster, supra,* 690 F.2d 323 at 329; *Standard Oil Company of California v. Agsalud, supra,* 633 F.2d 760, 766 (9th Cir. 1980), *aff'd mem.,* 454 U.S. 801 (1981) and *Hewlett-Packard Company v. Barnes,* 571 F.2d 502 (9th Cir. 1978), *cert denied,* 439 U.S. 831 (1979).

Carriers' Conference Committee v. Heffernan, 454 F. Supp. 914 (D. Conn. 1978). That law required plans to pay a tax on benefits and at rates higher than those set for insurance companies. That court's rejection of the claimed exception for tax laws applies with equal force to this case:

> "The phrase 'any and all' plainly indicates an intention to reach every state statute that fits the description of 'relating to' an employee benefit plan. Just as plainly the tax imposed by §12-211c is such a statute. The statute is not merely a general taxing provision that catches employee benefit plans within its wide sweep. On the contrary, the tax is specifically directed at such plans exclusively, and is distinct from the tax applied to insurance company premiums. See Conn. Gen. stat. §12-202 (Supp. 1978). Clearly it 'relates to' ERISA covered plans."
>
> " . . .where Congress has not excluded even general tax statutes from pre-emption, a statute specifically directed at an ERISA-covered plan must certainly come within the pre-emption provision." 454 F.Supp. at 915, 916.
>
> "In the present action the challenged statute imposes a 2.75% annual tax on benefits paid by employee benefit plans. This contrasts with Connecticut's tax on the premiums received by insurance companies, which is only 2%. Conn. Gen. Stat. §12-202. *This tax structure may operate as an incentive to use traditional insurance, rather than ERISA-covered plans.* Although the impact of the tax discrepancy may be only nominal at present, its economic impact is not the measure of its significance. Rather, the discrepancy is

illustrative of the potential use of taxation as a means of regulation. Because of that potential, pre-empting state taxation of ERISA-covered plans is necessary to effectuate Congressional objectives." 454 F. Supp. at 918. (emphasis supplied).[17]

The fact is that Congress considered carefully the kind of state laws it desired to preserve from pre-emption and this statute falls within none of the exemptions.[18] There is simply no basis

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17. In creating, post *Agsulud*, a limited exception to pre-emption for the Hawaii Pre-Paid Health Care Act, Congress specifically directed that it *not* be construed to exempt from pre-emption "any state tax law relating to employee benefit plans . . ." ERISA Section 514(b)(5)(B)(i), 29 U.S.C. §1144(b)(5)(B)(i). *See also, Pervel, supra,* 468 F.Supp. at 493 (State law "can only add to the cost of administration and ultimately impose costs on plan beneficiaries."); *Stone & Webster Engineering Corp. v. Ilsley,* 690 F. 2d 323, 326 (2nd Cir. 1982), *aff'd, sub nom. Arcudi v. Stone and Webster Engineering Corporation,* _____ U.S. _____, 103 S.Ct. 3564 (1983); *Blue Cross and Blue Shield of Alabama v. Peacock's Apothecary,* 567 F. Supp. 1258 (N.D. Ala. 1983) (State law regulating discount pharmacy rate contracts pre-empted); *Dawson v. Whaland,* 529 F. Supp. 626, 632 (D.N.H. 1982) (New Hampshire statute, compliance with which represented only additional estimated $23,000 in administrative expenses to plaintiff funds held pre-empted); *General Split Corporation v. Mitchell,* 523 F. Supp. 427 (E.D. Wis. 1981) (Wisconsin's attempt to require employee benefit plans to participate in health insurance risk sharing plans (similar to the bad debt and charity pools established under the law in issue) which created administrative and other expenses for plan held pre-empted); *St. Paul Electrical Workers Welfare Fund v. Markman,* 490 F.Supp. 931 (D. Minn. 1980). Advisory Opinions from the Department of Labor finding that laws increasing plan expenses are pre-empted abound. *See* DOL Advisory Opinion No. 80-60A (Oct. 10, 1980) (California's Confidentiality of Medical Information Act pre-empted); DOL Advisory Opinion No. 81-70A (Illinois Law restricting the rate of interest which may be charged individuals in loan transactions pre-empted); DOL Advisory Opinion No. 79-40A (December 12, 1979) (State of California tax levies on plans for unpaid taxes or unpaid unemployment insurance contributions pre-empted).

18. If the State of New York feels strongly that it has a valid need to regulate or restrain self-insured ERISA funds in order to promote hospital cost

(Cont'd)

to conclude that a law directly aimed at and intended to proscribe the transactions of employee benefit plans is not pre-empted. *Kilberg* urged:

> "In the state law context, an apparent purpose to regulate, manifested by a reference to employee benefit plans in the text of the law, invariably reflects an actual regulatory purpose. Hence, any law expressly directed toward employee benefit plans 'purports' to regulate the plans within the meaning of section 514.
>
> Congress meant to pre-empt such state laws, however, whether or not they are styled as employee benefit plan regulations. In light of this congressional intent, 'purports' must be construed in its 'normal sense' of 'to have in mind.' " 62 Texas L.R. at 1328, 1329. (Footnotes omitted).[19]

(Cont'd)
containment then it is free to present its case to Congress as the State of Hawaii did in achieving a limited exception to pre-emption for its health care law. *See* ERISA Section 514(b)(5), 29 U.S.C. §1144(b)(5).

19. While the Fund does not agree that a finding of purpose is necessary under Section 514(a), of course, if a state's purpose *is* to regulate employee benefit plans, its action unquestionably "relates to" such plans. As recognized by both the majority and dissenting opinions in *Garcia v. San Antonio Metropolitan Transit Authority*, Nos. 82-1913 and 82-1951 (February 19, 1985), attempts to draw boundaries and identify organizing principles governing broad concepts of federalism are difficult. Congress eliminated this need in Section 514(a) by providing the "relate to" standard of pre-emption. Under it, there is no need to construct rules that would limit the impact of pre-emption. It does not matter whether the relation arises from the purpose of a statute, its impact on employee plans in general, or its application to a particular plan. Any one or all of these examples can give rise to the kind of state action Congress intended to foreclose.

In a footnote to the quoted passage, the article cited with approval the district court opinion in this case.

The conclusion that the state law here does not "relate to" ERISA plans, above all, ignores this Court's unanimous determination in *Shaw* that Congress intended the plain English meaning of the term to control:

> "The breadth of §514(a)'s pre-emptive reach is apparent from that section's language. A law 'relates to' an employee benefit plan, in the normal sense of the phrase, if it has a connection with or reference to such a plan." 103 S.Ct. 2890, 2899-2900 (1983).

The opinion below is directly at odds with the opinions of this Court and should be reviewed.

CONCLUSION

For these reasons, a writ of certiorari should be granted.

Dated: New York, New York
February 22, 1985

Respectfully submitted,

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OPINION OF THE UNITED STATES COURT OF APPEALS FOR THE SECOND CIRCUIT DECIDED NOVEMBER 26, 1984

UNITED STATES COURT OF APPEALS

FOR THE SECOND CIRCUIT

Cal. No. 1466 — August Term, 1983

(Argued: June 14, 1984 Decided: November 26, 1984)

Docket No. 84-7388

SEBASTIAN REBALDO, as Chairperson of the Board of Trustees of the UNITED OPTICAL WORKERS INSURANCE FUND,

Plaintiff-Appellee,

v.

MARIO CUOMO, Governor of the State of New York; and DAVID AXELROD, Commissioner of Health of the State of New York,

Defendants-Appellants.

Before:

FRIENDLY, VAN GRAAFEILAND and NEWMAN, *Circuit Judges.*

Appeal from a judgment of the United States District Court for the Southern District of New York (Conner, *J.*) declaring N.Y. Pub. Health Law § 2807-a(6)(b) partially invalid and enjoining its enforcement insofar as it affects hospital charges to self-insured employee benefit plans covered by the Employee Retirement Income Security Act, 29 U.S.C. §§ 1001-1461.

Vacated and remanded.

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VAN GRAAFEILAND, *Circuit Judge:*

This is an appeal from a judgment of the United States District Court for the Southern District of New York (Conner, *J.*), which invalidated section 2807-a(6)(b) of New York's Public Health Law to the extent it prohibits a hospital from establishing inpatient charges for self-insured employee benefit plans that are other

than the charges authorized by the section. The provisions of the statute thus invalidated precluded self-insured employee benefit plans such as the United Optical Workers Insurance Fund (United) from negotiating discount rates with hospitals similar to the rates permitted for payors such as Blue Cross, which operates under Article IX-C of New York's Insurance Law.

In holding as it did, the district court adopted appellee's contention that New York's right to set hospital rates chargeable to employee benefit plans was preempted by section 514(a) of the Employee Retirement Income Security Act (ERISA), 28 U.S.C. § 1144(a), which states with certain exceptions that the provisions of ERISA shall supersede State laws insofar as they "relate" to any employment benefit plan. For reasons hereafter stated, we believe that appellee's contention should have been rejected.

During the past several decades, the cost of hospital care has spiraled. *See Greater New York Hospital Association* v. *Blum*, 634 F.2d 668, 669 (2d Cir. 1980); *California Welfare Rights Organization* v. *Richardson*, 348 F. Supp. 491, 496 (N.D. Cal. 1972). In 1983, approximately $8 billion was spent on inpatient hospital care in the State of New York alone. Because approximately two-thirds of this amount was paid by Medicaid and Medicare, both the federal and state governments have sought to develop systems of cost control. However, since Medicaid controls have been more exacting than those of Medicare, administrative attempts to contain hospital costs have been more successful in the former than in the latter.

Medicaid is a joint state and federal program designed to provide medical care to those who otherwise

could not afford it. *Hospital Association of New York, Inc.* v. *Toia*, 577 F.2d 790, 792 (2d Cir. 1978). New York State is one of the voluntary participants in this plan, which it administers in compliance with applicable federal statutes and regulations. In return for such compliance, the federal government has obligated itself to fund up to 60% of the cost of New York's program. 42 U.S.C. § 1396a(a)2.

Almost from the time when New York opted to participate in the Medicaid program, *see* N.Y. Soc. Serv. Law § 363-a, the State has been engaged in a continuing attempt to keep hospital costs within reasonable limits. Prior to 1970, New York reimbursed hospitals on the basis of their actual costs. In 1969, the State decided that this method was too costly and that, effective January 1, 1970, payments would be made in accordance with predetermined rate schedules that reasonably were related to the costs of the services performed. *See Hospital Association of New York State, Inc.* v. *Toia*, *supra*, 577 F.2d at 792 n.1; *National Union of Hospital and Health Care Employees* v. *Carey*, 557 F.2d 278, 279-80 (2d Cir. 1977). Although modified by subsequent legislation, that is the basic manner in which payments are made today.

Medicare, which was established to provide medical care to the elderly, is funded entirely by the federal government. Traditionally, states have played no role in setting Medicare rates or handling Medicare payments. *Mount Sinai Hospital of Greater Miami, Inc.* v. *Weinberger*, 517 F.2d 329, 334 (5th Cir. 1975), *cert. denied*, 425 U.S. 935 (1976). Thus, in contrast to the prospective rate setting method adopted for Medicaid in New York, Medicare continued until 1982 to calculate hospital entitlements on the basis of costs computed at the end of each fiscal year.

As early as 1967, however, Congress realized that "the rigid commitment to a cost basis of reimbursement may provide insufficient incentive for participating providers of services to furnish health care economically and efficiently", and concluded that bases of Medicare reimbursement other than the cost method should be explored experimentally. S. Rep. No. 744, 90th Cong., 1st Sess. *reprinted in* 1967 U.S. Code Cong. & Ad. News 2834, 2905. This realization led to the enactment of Pub. L. No. 90-248, tit. IV, § 402(a), (b), 81 Stat. 930, 931, the precursor of 42 U.S.C. § 1395b-1. In substance, section 402(a),(b) authorized the Secretary of Health, Education and Welfare to develop and engage in experiments under which hospitals would be reimbursed in a manner leading to increased efficiency without any impairment of quality. Section 402(c) of the 1967 statute amended section 1875(b) of the Social Security Act, now 42 U.S.C. § 1395*ll* to provide that the Secretary should submit an annual report to Congress concerning the experiments and demonstration projects authorized by Section 402 (a),(b).

Section 222 of Pub. L. No. 92-603, tit. II, 86 Stat. 1390, enacted in 1972, continued and enlarged upon the Secretary's authority to conduct experiments and demonstration projects. Anticipating that Medicaid and private insurers might participate in these experiments, Congress expressed its intent that "Medicaid and private funds would also be used proportionately when medicaid and private programs participate in the project." H.R. Rep. No. 231, 92d Cong., 2d Sess., *reprinted in* 1972 U.S. Code Cong. & Ad. News 4989, 5068. *See* 42 U.S.C. § 1395b-1 (a)(2).

By the time Congress decided in 1983 to convert Medicare substantially to a system of predetermined

prospective rates, *see* Pub. L. No. 98-21, tit. VI, § 601, 97 Stat. 149 (1983), *codified at* 42 U.S.C. § 1395ww(d), (e),(f), demonstration projects had been established in Maryland, Massachusetts, New Jersey, and New York. Section 603(b) of the 1983 Act, which may be found in the Historical Note following 42 U.S.C. § 1395b-1, provided that "the amendments made by this title shall not affect the authority of the Secretary to develop, carry out, or continue experiments and demonstration projects." In commenting on section 603(b), the report of the House Ways and Means Committee stated:

> Your Committee believes that State cost containment systems have proven effective in reducing the cost of hospital care and that such systems should be encouraged. It is the intent of this provision that the Secretary continue medicare waivers for States which currently have effective demonstration projects and provide an opportunity for new States to develop sound approaches to cost containment. State systems covering all payors have proven effective in reducing health costs and should be encouraged. Such State programs may be useful models for our national system.

H.R. Rep. No. 25, 98th Cong., 1st Sess. 147-48, *reprinted in* 1983 U.S. Code Cong. & Ad. News 219, 366-67.

The Committee's report continues:

> Your Committee bill provides that, upon the request of the State, the Secretary is required to modify the terms of the New York and Massachusetts waivers to eliminate the requirement that the State rate of increase in medicare hospital costs be below the national rate.
>
> . . . .

> Under your Committee's bill and under the current demonstration authority of the Secretary, State systems are required to meet a savings test that is related to medicare.

Id.

The statute invalidated below is part of New York's experiment and demonstration project, a three-year program beginning January 1, 1983. The program was approved by the Secretary on December 21, 1982, pursuant to the authority granted by section 402(a). In pertinent part, this plan provides that the State Commissioner of Health shall establish for each hospital an "inpatient revenue cap", i.e., the maximum amount of inpatient revenue the hospital will be authorized to receive for services during a twelve-month period, N.Y. Pub. Health Law § 2807-a(1), with additional allowances being made for bad debts and charity care, *id.* at (4). Each general hospital is required to establish a charge schedule sufficient to generate the inpatient revenue authorized by the revenue cap, with a proviso that the rate for Article IX-C corporations such as Blue Cross shall be at a discount of from 12% to 15% below that of other non-governmental payors such as United. The statute excepts from this rate differential health maintenance organizations certified under Article 44 of New York's Public Health Law and self-insured and self-administered groups that had hospital rate contracts in effect on May 1, 1982. *Id.* at (6). Because United is not an Article 44 health maintenance organization and had no rate contract in effect on May 1, 1982, it did not fall within the excepted group.

Appellee commenced this action on December 1, 1983. In addition to his claim of preemption under ERISA,

appellee alleged that subsection 6(b) unconstitutionally impaired the obligation of contracts, burdened interstate commerce, denied United equal protection of the law, was void and preempted by the Constitution's supremacy clause, and established anti-competitive price discrimination in violation of the federal antitrust laws. Because the district court held that the rate setting provisions of the statute, as they applied to self-insured employee benefit plans, were preempted by ERISA, the court found it unnecessary to reach appellee's other contentions. The sole issue before this Court, therefore, is whether Congress, in enacting ERISA, intended to preclude the subsequent adoption of experimental and demonstration projects, such as the one at issue herein, to the extent that those plans prescribe hospital rates chargeable to self-insured employee benefit plans.

Appellants' principal argument on appeal is that the setting of rates that hospitals must charge private payors, a group that includes employee benefit plans, does not "relate" to United's plan within the meaning of section 514(a). Appellee's initial response to this argument, albeit a response made almost in passing, is that it was not made in the district court and therefore should not be heard here. Although generally this Court will not consider an issue not passed on below, *Singleton* v. *Wulff*, 428 U.S. 106, 120 (1976), we may, under proper circumstances, make exceptions to this rule, *id.* at 121; *Chico* v. *Schweiker*, 710 F.2d 947, 952 (2d Cir. 1983); *see also Davis* v. *Musler*, 713 F.2d 907, 917 (2d Cir. 1983) (Van Graafeiland, J., concurring) and cases there cited. Because the district court examined the issue of relationship in some detail and because that court's decision has broad legal ramifications and concerns the validity of a State statute, we think this is a case for such an exception.

Moreover, both parties as well as *amici* have fully briefed and argued before this Court whether this New York law "relates to" ERISA plans within the meaning of § 514(a), and the issue is solely one of law the determination of which could not be altered by appellee's producing additional evidence.

Section 514(a) of ERISA, 29 U.S.C. § 1144(a), provides that "the provisions of this title and title IV shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan . . . ." In the definitional section, 29 U.S.C. § 1144(c)(2), Congress defined the term "State" for ERISA preemption purposes as follows:

> The term "State" includes a State, any political subdivisions thereof, or any agency or instrumentality of either, which purports to regulate, directly or indirectly, the terms and conditions of employee benefit plans covered by this subchapter.

Thus, a state law must "purport[] to regulate, . . . the terms and conditions of employee benefit plans" to fall within the preemption provision. Appellee contends that this phrase should not be read to impose any special limitation in determining whether the hospital rate regulation in the instant case relates to United.[1] We disagree.

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[1] Appellee relies for this argument on a report issued after the passage of ERISA by the House Committee on Education and Labor that concluded that the phrase "which purports to regulate" modifies "agency or instrumentality" only and does not modify the term "State." H.R. Rep. No. 1785, 94th Cong., 2d Sess. 47-48 (1977). Such reports, although often persuasive, are not binding. We reject this Report's analysis as lacking even persuasive authority. In *Alessi* v. *Raybestos-Manhattan, Inc.*, 451 U.S. 504, 525 (1981), the Supreme Court held that the phrase "directly or indirectly" modified both "State" and "agency or instrumentality."

[Footnote continued on following page]

As the district court quite properly recognized, the Supreme Court has given the term "relate" as used in ERISA a broad and liberal construction. *See Shaw* v. *Delta Air Lines, Inc.*, 103 S. Ct. 2890, 2899-900 (1983). However, the preemptive scope of ERISA is neither all-encompassing, *Lane* v. *Goren*, No. 83-6496, slip op. 4263, 4265 (9th Cir. Sept. 27, 1984), nor unlimited, *Savings and Profit Sharing Fund of Sears Employees* v. *Gago*, 717 F.2d 1038, 1040 (7th Cir. 1983). ERISA does not invalidate those State statutes whose effect on pension plans is simply tangential in nature. *Shaw* v. *Delta Air Lines, Inc., supra*, 103 S. Ct. at 2901 n.21; *American Telephone & Telegraph Co.* v. *Merry*, 592 F.2d 118, 121 (2d Cir. 1979). This conclusion follows as a matter of common sense from the fact that ERISA plan members and managers are bound to engage in myriad transactions that Congress never considered when it drafted § 514. A preemption provision designed to prevent state interference with federal control of ERISA plans does not require the creation of a fully insulated legal world that excludes these plans from regulation of any purely local transaction.

The containment of hospital costs is an exercise of a State's police powers, which should not be superseded by federal regulations unless that was the clear intent of Congress. *Alessi* v. *Raybestos-Manhattan, Inc.*, 451 U.S.

[Footnote continued from previous page]

This entirely sensible reading follows naturally the structure of the sentence and its punctuation, and we see no reason to read the immediately preceding clause, "which purports to regulate," any differently. Thus, even without the decision in *Alessi*, we would read the phrase "which purports to regulate, . . . the terms and conditions of employee benefit plans" as modifying the term "State." *Accord, Lane* v. *Goren*, No. 83-6496, slip op. 4263, 4265 (9th Cir. Sept. 27, 1984).

504, 522 (1981); *Massachusetts Nursing Association* v. *Dukakis*, 726 F.2d 41, 44 (1st Cir. 1984); *see Ray* v. *Atlantic Richfield Co.*, 435 U.S. 151, 157 (1978). Accordingly, a State's promulgation of hospital rate schedules should not be found to "relate" to "the terms and conditions of employee benefit plans" unless this conclusion is unavoidable. *See Alessi* v. *Raybestos-Manhattan, Inc.*, *supra*, 451 U.S. at 522.

It is clear that ERISA preempts state laws that require or forbid the provision of a certain kind of benefit. *See, e.g., Stone & Webster Engineering Corp.* v. *Ilsley*, 690 F.2d 323, 329-30 (2d Cir. 1982), *aff'd sub nom. Arcudi* v. *Stone & Webster Engineering Corp.*, 103 S. Ct. 3564 (1983) (state law requires provision of health insurance to former employee receiving workmen's compensation). It is equally clear that ERISA does not preempt every state law that incidentally touches pension plans through its effect on individuals. *See, e.g., American Tel. & Tel. Co.* v. *Merry*, *supra*, 592 F.2d at 123-26 (garnishment of pension benefits to collect alimony and child support). As said in *Shaw* v. *Delta Air Lines, Inc.*, *supra*, 103 S. Ct. at 2901 n.21: "Some state actions may affect employee benefit plans in too tenuous, remote, or peripheral a manner to warrant a finding that the law 'relates to' the plan." New York's decision to regulate the amounts hospitals can charge falls within this description. Appellee's suggestion that, because this regulation affects pensions plans in their dealings with hospitals by increasing their costs of doing business, it must be found preempted, proves altogether too much. As the court observed in *Lane* v. *Goren*, *supra*, slip op. at 4266:

> That argument does not withstand scrutiny. So too, for example, do State laws and municipal ordinances regulating zoning, health, and safety increase the

operational costs of ERISA trusts, but no one could seriously argue that they are preempted.

See also American Progressive Life & Health Insurance Co. v. *Corcoran*, 715 F.2d 784, 787 (2d Cir. 1983).

The purchase of hospital service is like the purchase of public utility service, or of any other service or commodity whose price is controlled by the State. Insofar as the regulation of hospital rates affects a plan's cost of doing business, it also may be analogized to State labor laws that govern working conditions and labor costs, to rent control laws that determine what employee benefit plans pay or receive for rental property, and even to such minor costs as the Thruway, bridge and tunnel tolls that are charged to plans' officers or employees. In short, if ERISA is held to invalidate every State action that may increase the cost of operating employee benefit plans, those plans will be permitted a charmed existence that never was contemplated by Congress. Where, as here, a State statute of general application does not affect the structure, the administration, or the type of benefits provided by an ERISA plan, the mere fact that the statute has some economic impact on the plan does not require that the statute be invalidated.[2]

Moreover, such indirect economic impact as may result from State control over hospital rates does not run counter to ERISA's aim of national uniformity in plan

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[2] The mere fact that section 2807 recognizes differences between groups, including "self-insured groups" like United, and tempers its treatment of these groups to reflect these differences, does not make it any the less a law of general application for preemption analysis. *Cf. New York Tel. Co.* v. *New York State Dept. of Labor*, 440 U.S. 519 (1979) (New York unemployment benefit law that gives special treatment to striking employees is "a law of general application," and thus is not preempted by NLRA).

regulation. *See Shaw* v. *Delta Air Lines, Inc., supra*, 103 S. Ct. at 2890 n.20. There is no valid reason why employee benefit plans cannot be subject to nationally uniform supervision despite dissimilarities in their costs of doing business. Indeed, if statutes such as section 2807-a(6)(b) of New York's Public Health Law are held to be preempted by ERISA, every hospital will be able to set its own rates for ERISA plans, and appellee does not contend that these rates are, or will be, uniform, even as between hospitals in the same locality. Lack of uniformity is not a valid argument for preemption of New York's statute.

The author of this opinion, writing only for himself and not his colleagues, who take no position on the issue, believes that New York's experimental and demonstration project, incorporated in section 2807-a, also is exempted from the preemptive provisions of ERISA by section 514(d) of that Act, which provides that nothing in ERISA shall be construed to "impair . . . any law of the United States . . . or any rule or regulation issued under any such law." 29 U.S.C. § 1144(d).

Medicaid has been described correctly as a "cooperative endeavor", a "cooperative program of shared financial responsibility" between the states and the federal government. *Harris* v. *McRae*, 448 U.S. 297, 308-09 (1980). It is "one of the 'cooperative federalism' welfare programs administered jointly by state and federal governments." *Massachusetts General Hospital* v. *Sargent*, 397 F. Supp. 1056, 1061 (D. Mass. 1975). *See also King* v. *Smith*, 392 U.S. 309, 316 (1968). A federally authorized experimental and demonstration project that incorporates both Medicaid and Medicare certainly is no less a cooperative undertaking.

As already pointed out, Congress authorized the Secretary of Health, Education and Welfare "to develop and engage in experiments and demonstration projects . . . to determine whether the rates of payment . . . for health care services, approved by a State for purposes of the administration of one or more of its laws, when utilized to determine the amount to be paid for services furnished in such State under the health programs established by this chapter, would have the effect of reducing the costs of such programs without adversely affecting the quality of such services." 42 U.S.C. § 1395b-1(a)(1)(C). This statute unambiguously vests the Secretary with authority to engage in such experiments. *Blue Cross Association* v. *Harris*, 622 F.2d 972, 976 (8th Cir. 1980).

> It is a commonplace of statutory construction that a legislative grant of power carries with it the right to use the means and instrumentalities necessary to the beneficial exercise of that power.

Id. at 978. *See also Health Care Service Corp.* v. *Califano*, 601 F.2d 934, 935 (7th Cir. 1979); *California Welfare Rights Organization* v. *Richardson*, *supra*, 348 F. Supp. at 493, 495.

In fact, Congress did more than merely authorize the Secretary to approve New York's demonstration project. In section 603b(1) of the 1983 Act, Congress ratified what the Secretary had done by authorizing the continuation of the established project. The program under review is not simply a New York undertaking; it is a cooperative undertaking of the state and federal governments.

The need for such experimental projects in the continually developing field of public health and assistance

is obvious. "A purpose to determine whether and how improvements can be made in the welfare system is as 'legitimate' or 'appropriate' as anything can be." *Aguayo* v. *Richardson*, 473 F.2d 1090, 1109 (2d Cir. 1973). *See California Welfare Rights Organization* v. *Richardson*, *supra*, 348 F. Supp. at 497. Indeed, the predetermined rate scheduling procedure that New York adopted for Medicaid in 1970 began its existence as an experimental or demonstration project with the approval of the Secretary and later was adopted as a permanent basis for payments. The above outlined history of the numerous congressional enactments authorizing experiments and demonstration projects shows the consistent intent of Congress that such experiments be conducted. When Congress gives authority with one hand, it ordinarily does not take it away with the other.

In attempting to control hospital charges, a State has the choice of setting rates for specific services, a procedure that is both cumbersome and expensive, or of prescribing a "revenue cap" for all services, a procedure that eliminates much of the administrative morass inherent in selective rate setting and gives hospitals some leeway in fixing specific charges. In order for the "revenue cap" concept to operated properly, a plan must provide, as New York's does, for an equitable apportionment of hospital costs among all payors, including the costs of bad debts and charity care. Indeed, the Medicare Act specifically prohibits the shifting of costs between Medicare and non-Medicare payors. 42 U.S.C. § 1395x(v)(1)(A). *See Greater New York Hospital Association* v. *Matthews*, 536 F.2d 494, 499 (2d Cir. 1976); 10 N.Y. Admin. Code, tit. 10, § 86-1.11(b). Were the Secretary prevented from approving experimental reimbursement programs that attempt to regulate all sources of hospital inpatient revenue

and equitably apportion responsibility for bad debt and charity care, the statutory mandate for such experimental programs would be impaired substantially.

In sum, the writer does not believe that Congress intended that ERISA would preempt a project of cooperative federalism, such as we have here, a project that was authorized and ratified by federal statute and is intended in substantial part to conserve federal funds.

The district court's judgment is vacated and the matter is remanded for further proceedings consistent with this opinion.

OPINION AND ORDER OF THE UNITED STATES DISTRICT COURT, SOUTHERN DISTRICT OF NEW YORK DATED MARCH 12, 1984

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

83 Civ. 8707
(WCC)

SEBASTIAN REBALDO, as Chairperson of the Board of Trustees of the UNITED OPTICAL WORKERS INSURANCE FUND,

Plaintiff,

- against -

MARIO CUOMO, Governor of the State of New York, and DAVID AXELROD, Commissioner of Health of the State of New York,

Defendants.

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CONNER, D. J.:

Opinion and Order

Plaintiff Sebastian Rebaldo ("Rebaldo") filed this action on behalf of the United Optical Workers Insurance Fund (the "Fund") in December 1983, seeking declaratory and injunctive relief against implementation of a small portion of the New York Prospective Hospital Reimbursement Method (the "NYPHRM"), New York Public Health Law §2807-a, *et seq.* Among its provisions, the NYPHRM establishes one method of hospital reimbursement for major third-party payors such as Medicare, Medicaid and Blue Cross, and another for all other payors. Rebaldo contends that the subsection in question, §2807-a.6(b), which mandates that rates for charge-paying individuals and groups such as the Fund be set at levels from 12% to 15% higher than rates set for corporations like Blue Cross, is invalid as applied to the Fund. He reasons that because this subsection restricts the right of an employee welfare benefit plan to negotiate with hospitals for reduced rates, it is pre-empted by the Employee Retirement Income Security Act of 1974, 29 U.S.C. §1001 *et seq.* (1976 ed. and Supp. V)("ERISA"). Defendants Mario Cuomo, the Governor of the State of New York, and David Axelrod, the Commissioner of Health, are the state officials charged with enforcing the NYPHRM. The matter is now before the Court on cross-motions for summary judgment.[1]

The Fund is a self-insured and self-administered employee welfare benefit plan governed by a board of trustees, of which Rebaldo is the chairman. The Fund receives contributions from employers in various states pursuant to the terms of collective bargaining agreements between the employers and the United Optical Workers, Local 408, and the resulting fund is used to provide hospital and other health and welfare coverage for employees and their dependents. Rebaldo Aff. at ¶1. The parties to this action and *amicus* Blue Cross agree that the Fund is governed by ERISA. Pl's Mem. at 2; Def's Mem. at 2; *Amicus* Mem. at 19.

Prior to 1983 the Fund purchased insurance coverage through Blue Cross. However it suffered financial losses under this arrangement, and in 1982, it retained Donald Rubin ("Rubin") to explore the possibility of self-insuring. Rubin concluded that by self-insuring, the Fund could provide superior benefits at reduced costs. Under his guidance, the Fund terminated its relationship with Blue Cross effective January 1, 1983, and converted to a self-insured and self-administered plan. On behalf of the Fund, Rubin negotiated discount contracts with more than 100 area hospitals; these contracts called for payment rates calculated at 5% above the discount rate paid by Blue Cross. As a result of these negotiated discount arrangements, as well as increased efficiency and lower administrative costs, the Fund estimates that it saved approximately $100,000 in hospitalization costs in 1983 by self-insuring. *Id.* at ¶3.

The New York Legislature enacted the NYPHRM in 1982, following years of proposals and recommendations aimed at remedying a vast array of hospital cost containment problems caused by such conditions as spiraling inflation, inability to cover bad debts and charity care, inadequate efficiency incentives and an inequitable distribution of financial burdens on various categories of payors. *See generally* Ex.A to Sweeney Aff. The ultimate goal of the statute, as characterized by the Director of the Office of Health Systems Management of the New York State Department of Health, is the attaining "financial stability for the hospital industry while at the same time promoting cost containment and overall increased efficiency in hospital operation." Sweeney Aff. at ¶19. The NYPHRM seeks to accomplish this end through a complex and comprehensive "reimbursement methodology" that accounts for and controls all sources of hospital revenue. The central concept is that of an "inpatient revenue cap" established for each hospital, which determines the maximum amount of inpatient revenue the hospital

may receive for services in a given year. Section 2807-a.1; Lovett Aff. at ¶14,; Miller Aff. at ¶4. Once the dollar figure is fixed for each hospital, it is allocated among various categories of payors, in part by the subsection at issue here.

Hospitals receive the great bulk of their revenue for patient care from third-party payors rather than from the personal funds of individual patients. Medicare, Medicaid and Blue Cross account for approximately 80% of payments for hospital care in New York, and the remaining percentage is attributable primarily to private insurance companies, self-insured groups such as the Fund, and individual "self-pay" patients (collectively "charge payors"). Sweeney Aff. at ¶4. In order to implement a comprehensive system to contain hospital costs, and to prevent hospitals from "juggling" reimbursement among payors, making up losses in one area with higher revenues from another, the legislature concluded that it would be necessary to achieve control over the rates paid by each of these groups. Sweeney Aff. at ¶¶20, 25.

The New York State Department of Health already regulated Medicaid reimbursement rates, Sweeney Aff. at ¶5, and similar controls had been exerted over rates charged to Blue Cross, a not-for-profit corporation which is organized pursuant to Article IX-C of the New York Insurance Law, and which is therefore subject to considerable state regulation. Lovett Aff. at ¶3; Sweeney Aff. at ¶9. Prior to the enactment of the NYPHM, however, the federal government had sole responsibility for establishing reimbursement rates for the Medicare program, Sweeney Aff. at ¶7, and the State made no attempt to control self-insured groups that wished to negotiate their own discount rates. In order to bring Medicare reimbursement rates under state control, New York proposed and received from the Office of Research and Demonstration of the federal Health Care Financing

Administration, Ex. A to Lovett Aff., a waiver under which the state was permitted to establish its own method of setting Medicare rates during an experimental three-year period. Sweeney Aff. at ¶¶8, 10.[2] Control over the rates charged to self-insured groups was achieved by the enactment of §2807-a.6.

Section 2807-a.6(a) requires that each hospital establish a charge schedule that will be sufficient to generate the inpatient revenue authorized by the revenue cap. Section 2807-a.6(b) then requires that as of January 1, 1984, each hospital's gross charges shall be set at a level such that the reimbursement rates paid by Blue Cross and other Article IX-C corporations are from 12% to 15% lower than the rates billed to charge-paying patients. In other words, self-insured groups such as the Fund must be charged by each hospital at its full or "gross" rates. Lovett Aff. at ¶16. An express exception not applicable to the Fund's contracts allows for the continuation of negotiated discount systems which were in effect on May 1, 1982.

Plaintiff seeks relief from this Court because the terms of §2807-a.6(b) effectively nullified its negotiated contracts as of January first of this year. He has submitted letters from the administrators of various hospitals with which contracts had been arranged, terminating those agreements "in compliance with section 2807-a(6)(b)." Ex. A to Rebaldo Reply Aff., Ex. A to Rubin Aff. Rebaldo asserts that §2807-a.6(b) "relates to" ERISA plans, and that it therefore falls within the broad scope of ERISA's pre-emption provision. Defendants concede that the subsection relates to ERISA plans, but argue that it escapes pre-emption under two of ERISA's savings clauses, one of which exempts state laws that regulate insurance, and the other which forbids construing ERISA'S preemption provision so as to alter, amend or modify federal law. For the reasons set forth below, I conclude

that §2807-a.6(b) is pre-empted by ERISA, and therefore may not be enforced against funds such as that administered by plaintiff.

Discussion

ERISA is a comprehensive body of federal law designed to promote and protect the interests of employees and their beneficiaries in pension and welfare benefit plans. 29 U.S.C. §1001. An "employee welfare benefit plan" is any plan, fund or program that provides medical, surgical or hospital care or benefits for contingencies such as illness, accident, disability, death or unemployment, 29 U.S.C. §1002(1), and all parties to this action agree that plaintiff's Fund is covered by the terms of this provision. The instant dispute arises under ERISA's pre-emption provision, §514(a), 29 U.S.C. §1144(a), ("§514(a)") and the savings clauses that follow.

With certain exceptions discussed below, §514(a) pre-empts "any and all State laws insofar as they may now or hereafter relate to any employee benefit plan" covered by ERISA. The scope of this provision was widely debated after ERISA's enactment, but much of the controversy was put to rest by the Supreme Court in *Shaw v. Delta Air Lines*, ____ U.S. ____, 103 S.Ct. 2890 (1983). The unanimous Court announced in *Shaw:*

> The breadth of §514(a)'s pre-emptive reach is apparent from that section's language. A law "relates to" an employee benefit plan, in the normal sense of the phrase, if it has a connection with or reference to such a plan.

Id. at 2899. The Court then cited Black's Law Dictionary for its definition of the term "relate": "To stand in some relation;

to have bearing or concern; to pertain; refer; to bring into association or connection with." *Id.*, n.16. This definition is consistent with ERISA's §514(c)(2), which provides that ERISA pre-empts any state action "which purports to regulate, *directly or indirectly,*" the terms or conditions of covered plans. (emphasis supplied). *See Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504, 525 (1980) ("It is of no moment that New Jersey intrudes indirectly, through a workers' compensation law, rather than directly, through a statute called "pension regulation". ERISA makes clear that even indirect state action bearing on private pensions may encroach upon the area of exclusive federal concern.") The Supreme Court went on to say in *Shaw* that in using the words "relate to" in their broadest sense, Congress rejected the suggestion that §514(a) be interpreted to preempt only state laws dealing with the subject matters specifically covered by ERISA, such as reporting, disclosure and fiduciary responsibility.

The Court recognized that requiring multi-state plans such as Rebaldo's Fund to comply with varying state regulations would have the direct effect of increasing the costs and decreasing the efficiency of fund administration. These increased costs, the Court reasoned, would eventually. result in a reduction of benefits to participants.

> The employer might choose to offer a number of plans, each tailored to the laws of particular states; the inefficiency of such a system presumably would be paid for by lowering benefit levels . . . . ERISA's comprehensive pre-emption of state law was meant to minimize this sort of interference with the administration of employee benefit plans.

103 S.Ct. at 2904, n.25.

ERISA's legislative history was given considerable attention in *Shaw*. The Court extensively quoted the bill's sponsors, who noted as ERISA's crowning achievement its reservation to federal authority of "the sole power to regulate the field of employee benefit plans," and who anticipated that the statute would eliminate any threat of conflicting or inconsistent state and local regulation. *Id.* at 2901, *quoting* Remarks of Representative Dent and Senator Williams, 120 Conf.Rec. 29197 and 29933 (1974). The Court also cited remarks by Senator Javits, who described the "emergence of a comprehensive and pervasive Federal interest" and who recognized that "the interests of uniformity with respect to interstate plans required — but for certain exceptions — the displacement of state action in the field of private employee benefit programs." *Id.* at 2901 n.20, *quoting* 120 Cong. Rec. 29942.

In light of this legislative history, the Supreme Court determined that the specific enumerated exceptions to the pre-emption provision should be narrowly construed. *Id.* at 2902, 2903. ("As we have detailed above, Congress applied the principle of pre-emption "in its broadest sense to foreclose any non-Federal regulation of employee benefit plans," creating only very limited exceptions to pre-emption").

Neither defendants nor *amicus* argues that §2807-a.6(b) does not "relate to" ERISA plans,[3] and such an argument would not prevail. Section 2807-a.6(b) adversely affects the administration of such plans in at least two ways . It is obvious that if the Fund is required to pay the higher reimbursement rates set for charge payors, it will not be able to provide the same breadth of coverage for its beneficiaries. Its other alternative is to return to the previous arrangement of purchasing insurance through Blue Cross, but the Fund asserts that its experience has shown this arrangement to be more expensive than the present system, and that some

reduction in benefits would still be necessary to cover increased costs.

In addition, by imposing a local condition on the administration of covered funds, §2807-a.6(b) runs afoul of ERISA's goal of facilitating the operation of uniform multi-state plans. In order to best conserve assets, the Fund might well find it practical to operate separate plans in different states; it might find that it could provide benefits most efficiently by insuring through Blue Cross in New York and by self-insuring in states without similar restrictions. This would result in higher administrative costs, and as the Supreme Court noted in Shaw, would eventually necessitate a decrease in benefits.

It should be noted, as well, that §2807-a.6(b)'s impact on ERISA plans is not incidental; it is apparent from the express exclusion of discount contracts entered into by "self-insured and self-administered groups" before May 1, 1982 that the legislature considered ERISA plans and fully intended to curtail their ability to negotiate or receive discounts after January 1, 1984. This conclusion is further supported by direct references to "self-insured groups [that] have negotiated payment rates with individual hospitals" in a report by the statutorily-created Council on Health Care Financing, which was charged with devising a plan for financing hospital inpatient care, and also by statements attributed to Edwin Werner, the President of Blue Cross and a member of the Council on Health Care Financing. In a memorandum entitled "Questions and Answers on the Changes in Financing Hospital Care in New York State," Ex.C to Rubin Aff., Werner discussed the impact of the NYPHRM on self-administered funds:

> These funds pay substantially less than other charges-paying patients; in several circumstances,

> their payment rates approximate [Blue Cross'] own. The unfairness of this became obvious to all in the course of the Council on Health Care Financing deliberations. As a result, under the Act, no new arrangements of this sort can be established after May 1, 1982.

Id. at p.7. In discussing the impact of the NYPHRM on Blue Cross, Werner then stated that the "abusive reimbursement practices of self-insured programs will be curtailed." *Id.* at p.8.

I am convinced, based upon the foregoing, that §2807-a.6(b) "pertains to" and "refers to" ERISA funds, and that it has a direct "bearing on" and "connection with" them. This conclusion by no means suggests that the designers of the NYPHRM acted with improper motives toward ERISA funds. To the contrary, defendants and *amicus* have provided the Court with considerable justification for the payment rate differential established between ERISA plans and corporations such as Blue Cross. The wisdom of §2807-a.6(b) is not at issue here, however, and I therefore turn to an examination of whether either of the proffered exceptions to ERISA's broad pre-emption rule apply.

Defendants and *amicus* assert that two of §514(a)'s narrow savings provisions apply to this controversy. The first is subsection (b)(2)(A) of §514, which excepts from pre-emption "any law of any State which regulates insurance." On its face, §2807-a.6(b) certainly does not purport to be an insurance law; it merely regulates the rates at which charge payors compensate hospitals for health care services. As noted above, this group of charge payors includes many individuals who are not covered by insurance at all. Nevertheless, it is apparent from the very existence of the present controversy that this measure has a regulatory effect on

insurance, and I therefore look to the intended meaning of the phrase "law which regulates insurance" in §514(b)(2)(A).[4]

ERISA itself provides no definition of this language, but both parties recognize that §514(b)(2)(A) is a reflection of congressional intent to accommodate the states' primacy in the area of insurance. Pl's Mem. at 6-7; Def's Mem. at 11-12. *See also Wadsworth v. Whaland,* 562 F.2d 70, 78 (1st Cir. 1977); *Eversole v. Metropolitan Life Ins. Co.,* 500 F. Supp. 1162 (C.D.Cal. 1980); *McLaughlin v. Connecticut General Life Ins. Co.,* 565 F. Supp. 434, 443 (N.D.Cal. 1973). That primacy was officially granted by Congress with the enactment of §2(b) of the McCarran Ferguson Act, 15 U.S.C. §§1011-1015 (1976)("the McCarran Act"), and thus it is appropriate to examine the language and background of the McCarran Act in construing ERISA's insurance savings clause.

The McCarran Act was passed in response to the Supreme Court's decision in *United States v. South-Eastern Underwriters Assn.,* 322 U.S. 533 (1944), which held that insurance transactions were subject to federal regulation under the Commerce Clause. Congress was apparently concerned that inroads might be made on the tradition of state insurance regulation, and it therefore sought to "give support to the existing and future state systems for regulating and taxing the business of insurance." *Prudential Ins. Co. v. Benjamin,* 328 U.S. 408, 429 (1946). It accomplished this by enacting §2(b), which provides in relevant part:

> No Act of Congress shall be construed to invalidate, impair, or supersede any law enacted by any State for the purpose of regulating the business of insurance, or which imposes a fee or tax upon such business, unless such Act specifically relates to the business of insurance . . . .

In *SEC v. National Securities, Inc.*, 393 U.S. 453 (1969), the Supreme Court discussed the meaning of the McCarran Act's "business of insurance" language. The Court stated first that in enacting the measure, Congress intended to assure that states retain the free hand they had previously enjoyed in "regulating the dealings between insurers and policyholders." It is the protection of this relationship, according to the Court, with which laws regulating the "business of insurance" are concerned.

> Insurance companies may do many things which are subject to paramount federal regulation; only when they are engaged in the "business of insurance" does the statute apply. Certainly the fixing of rates is part of this business; . . . *Congress was concerned with the type of state regulation that centers around the contract of insurance,* the transaction which *Paul v. Virginia* held was not "commerce." *The relationship between insurer and insured, the type of policy which could be issued, its reliability, interpretation, and enforcement — these were the core of the "business of insurance."* Undoubtedly, other activities of insurance companies relate so closely to their status as reliable insurers that they too must be placed in the same class. But whatever the exact scope of the statutory term, it is clear where the focus was — it was on the relationship between the insurance company and the policyholder. Statutes aimed at protecting or regulating this relationship, directly or indirectly, are laws regulating the "business of insurance."

Id. at 459-60 (emphasis added).

The Supreme Court again addressed the meaning of §2(b)'s "business of insurance" language in *Group Life & Health Insurance Co. a/k/a Blue Shield of Texas v. Royal Drug Co.*, 440 U.S. 205 (1979). *Royal Drug* involved agreements between Blue Shield and certain "participating" pharmacies, under which policyholders would pay only two dollars for each prescription drug purchased, and Blue Shield would then reimburse the pharmacies for the drug acquisition costs. Policyholders who purchased drugs at non-participating pharmacies would pay full price, and could seek partial reimbursement from Blue Shield. The only issue before the Court was whether the establishment of these pharmacy agreements between Blue Shield and the participating pharmacies constituted the "business of insurance" which, under the McCarran Act, could only be regulated by the state.

In concluding that entry into these agreements did nor constitute the "business of insurance," the Court first discussed the significance of risk-spreading as an indispensable characteristic of insurance. Rejecting Blue Shield's suggestion that the agreements did involve undewriting of risks, the Court said:

> The benefit promised to Blue Shield policy holders is that their premiums will cover the cost of prescription drugs except for a $2 charge for each prescription. So long as that promise is kept, policyholders are basically unconcerned with arrangements made between Blue Shield and participating pharmacies.
>
> The Pharmacy Agreements thus do not involve any underwriting or spreading of risk, but are merely arrangements for the purchase of goods

> and services by Blue Shield. By agreeing with pharmacies on the maximum prices it will pay for drugs, Blue Shield effectively reduces the total amount it must pay to its policyholders. The Agreements thus enable Blue Shield to minimize costs and maximize profits. Such cost-savings arrangements may well be sound business practice, and may well inure ultimately to the benefit of policyholders in the form of lower premiums, but they are not the "business of insurance."

Id. at 214-15 (footnotes omitted).

The Court went on to emphasize that the pharmacy agreements were simply contractual arrangements between Blue Shield and the pharmacies for the sale and distribution of goods and services other than insurance, and that they did not implicate the relationship between insurer and insured, which was at the heart of §2(b) of the McCarran Act. For these reasons, the Court concluded that the agreements were not "the business of insurance" within the meaning of that Act. *Id.* at 230.

In the instant case, the Fund negotiated with third parties for the delivery of health care services at a discount price. The contracts were designed to reduce the Fund's costs and preserve its assets, but they had no direct impact upon the relationship between the Fund and its beneficiaries. In short, within the meaning of the McCarran Act, the Fund was not engaging in the "business of insurance" when it executed the contracts affected by the implementation of §2807-a.6(b).

Of course, §514(b)(2)(A) of ERISA does not contain the "business of insurance" language found in the McCarran Act;

it refers simply to "any law . . . which regulates insurance" Nevertheless, several courts have concluded, correctly I believe, that the two provisions promote the same policy and should therefore be construed consistently. *See Wadsworth v. Whaland*, 562 F.2d 70, 78 (1st Cir. 1977) ("[T]he national policy of primacy in the regulation of insurance announced by Congress in the McCarran-Ferguson Act . . . is twice reaffirmed by ERISA in §514: first with the saving clause and again with subsection (d)"); *McLaughlin v. Connecticut General Life Insurance Co.*, 565 F. Supp. 434, 445 (N.D. Cal. 1983); *Eversole v. Metropolitan Life Insurance Co.*, 500 F. Supp. 1162, 1168 (C.D. Cal. 1980) ("The two statutes are *in pari materia* and should therefore be construed consistently"). In light of the Supreme Court's conclusion that the specific exceptions to ERISA's general pre-emption rule are to be construed narrowly, I see no purpose in interpreting the reference to insurance regulation in §514(b)(2)(A) more broadly than the corresponding reference in the McCarran Act. It follows, therefore, that §2807-a.6(b) of the New York Public Health Law is not saved from pre-emption under ERISA's insurance savings clause.

Blue Cross has proposed an alternative method of saving §2807-a.6(b) from pre-emption, inviting the Court's attention to §514(d) of ERISA. This subsection states:

> Nothing in this subchapter shall be construed to alter, amend, modify, invalidate, impair or supersede any law of the United States or any rule or regulation issued under any such law.
>
> *Amicus* contends that if this Court were to construe ERISA to pre-empt §2807-a.6(b), the federal government would be impaired in its ability to

discharge its responsibilities under the Medicare program, Title XVIII of the Social Security Act, 42 U.S.C. §1395 *et seq*. The theory, although creative, is also flawed.

Underlying Blue Cross's argument is a concern for the continued viability of the federal government's Medicare waiver, which was granted under a section of the Social Security Act designed to encourage experimentation with Medicare reimbursement at the state level, and which was, in fact, a condition precedent to implementation of the NYPHRM. The source of this concern is a provision, codified as a note to §2807,which provides that:

> if any payor reduces its rate of payment below that which is developed in accordance with the provisions of section twenty-eight hundred seven-a of the public health law, . . ., the provisions of this act shall have no force and effect and the provisions of the public health law as they existed immediately prior to the enactment of this act shall be restored and deemed to be in full force and effect.

1982 N.Y. Laws, ch. 536, §10(a). Blue Cross argues that even though plaintiff has asked the Court to enjoin application of §2807-a.6(b) only insofar as it applies to ERISA funds, the language quoted above forecloses any possibility of such limited relief — in other words, if §2807-a.6(b) is pre-empted, the whole scheme will be invalidated.

According to Blue Cross, when the Secretary of Health and Human Services granted the waiver, it thereby "adopted" the NYPHRM scheme for the federal Medicare program, *Amicus* contends this is precisely the sort of operational experiment Congress clearly sought to enable by enacting §514(d). *Amicus* letter of February 17, 1984, ¶6.

Plaintiff responds that NYPHRM's non-severability clause, §10(a) of L.1982, ch. 536, was intended only to assure the continuing participation of the state's three major payors, Medicare, Medicaid and Blue Cross, in the overall scheme, and does not apply to ERISA funds. Plaintiff suggests that another general severability clause, found at §2813 of the Public Health Law, operates to save §2807-a from pre-emption except to the extent that it is held unenforceable against ERISA funds, Pl's Reply Mem. at 17, and that pre-emption therefore poses no threat to the continued viability of the Medicare waiver.

Defendants and *amicus* have emphasized repeatedly the comprehensiveness of the NYPHRM, and the importance of incorporating into the reimbursement scheme all sources of hospital revenue. These considerations militate against adoption of plaintiff's construction of §10(a). On the other hand, plaintiff has correctly recognized that a literal construction of the language would lead to the absurd result that "a single uninsured patient who settled his hospital account for less than the charge payer rate would invalidate the statute." Pl's Reply Mem. at p.17 n.6. Given the importance of the objectives served by the NYPHRM, the extensive time and effort expended in designing and implementing the complex statutory scheme, and the obvious need for some degree of flexibility in its administration,[3] I believe that had the New York Legislature been presented with the ambiguity raised here, it would have clarified §10(a) or made some other

provision to avoid the drastic result predicted by *amicus*. My confidence is bolstered by the fact that the suggestion that pre-emption of §2807-a.6(b) would invalidate the NYPHRM in its entirety was raised not by the Office of the New York State Attorney General, but only by *amicus* Blue Cross. It would appear, then, that the defendants do not share Blue Cross's concern for the future of the NYPHRM.

Fortunately, it is not necessary for me to second-guess the New York Legislature in order to resolve the legal issue at hand. Even assuming the legislature fully intended that pre-emption of any one provision would result in the defeat of its entire statutory scheme and the nullification of the special Medicare waiver, I have concluded that such a disposition would not alter, modify or impair "any law of the United States or any rule or regulation issued under any such law" within the meaning of §514(d) of ERISA.

Medicare is a comprehensive health insurance program for elderly and disabled persons. Medicare Hospital Insurance (Part A) covers medically necessary inpatient care in a hospital, and thereafter in a skilled nursing facility, while Medicare Medical Insurance (Part B) primarily covers medically necessary outpatient services and supplies. The Secretary of Health and Human Services (the "Secretary") is granted authority under 42 U.S.C. §1302 to "make and publish such rules and regulations . . . as may be necessary to the efficient administration" of the Medicare program, and she has exercised that authority by publishing regulations governing reimbursement for services rendered to persons covered under Medicare Part A. *See* 42 C.F.R. §405 (1982). These regulations set forth the retrospective reimbursement procedure from which the New York State Department of Health sought relief in order to implement the NYPHRM.

The Secretary is authorized under 42 U.S.C. §1395b-1(a)(1)(c) to engage in experiments and demonstration projects designed to determine whether the rates of payment or reimbursement approved by a state for purposes of administering its own laws would reduce the cost of Medicare coverage without adversely affecting the quality of services. Section 1395b-1(b) provides that in the case of any experiment or demonstration project entered into under subsection (a), the Secretary may waive compliance with applicable reimbursement requirements. Under this authority, the Federal Health Care Finance Administration's Office of Research and Demonstrations issued a letter to the Commissioner of the New York State Department of Health on December 14, 1982, granting such a waiver. Ex.A to Lovett Aff.

Blue Cross has not suggested that the predicted nullification of the NYPHRM by pre-emption of §2807-a.6(b) would impair in any way the continued ability of the Secretary to grant waivers under 42 U.S.C. §1395b-1(b). It argues, instead, that the particular waiver granted for purposes of implementing the NYPHRM would be jeopardized, and that this waiver amounts to a "rule or regulation" which cannot be impaired under §514(d).[6]

> By formal action denominated "Waiver" (42 U.S.C. §1395b-1(b)(1976), throughout New York the Secretary has substituted for "rules and regulations" set forth in 42 C.F.R. those regulations for reimbursement under Medicare Part A prescribed by NYPHRM. . . . In effect, then, the Secretary's "Waiver" action has constituted adoption of new "regulations" to govern Medicare Part A reimbursement for New York.

Amicus letter of February 17, 1984, ¶3. For the several reasons set forth below, I cannot agree.

Section 514(d) of ERISA refers to "any rule or regulation issued under any federal law," but nowhere in the statute is that phrase defined. The Medicare waiver itself is surely not a federal regulation; it merely relieves Medicare providers in New York of their obligation to comply with federal regulations. A rule, in its broadest sense, may be "an agency statement of general or particular applicability," Administrative Procedure Act, 5 U.S.C. §551(4), but rulemaking by an agency "characteristically involves the promulgation of concrete proposals, declaring generally applicable policies binding upon the affected public generally. *PBW Stock Exchange Inc. v. SEC,* 485 F.2d 718, 732 (3d Cir. 1973), *cert. denied,* 416 U.S. 969 (1974). *See, e.g., Hospital Association of New York State v. Toia,* 438 F. Supp. 866, 872 (S.D.N.Y. 1977) (In approving New York State Medicaid plan, HEW acted in "neither an adjudicatory, nor a rule making capacity"); *Vandemark v. Housing Authority of the City of New York,* 663 F.2d 436, 440 (3d Cir. 1981). In determining whether the waiver is within this definition, I am of course cognizant of the Supreme Court's mandate that exceptions to ERISA's general pre-emption provision be narrowly construed. In light of that mandate, it is inconceivable that Congress intended to permit a state to circumvent ERISA's requirements merely by persuading a federal bureaucrat to act favorably upon a proposal that embodies otherwise impermissible measures, and then protecting this transgression by means of a non-severability clause.

The Medicare waiver was apparently obtained upon an *ex parte* application. There was no publication or opportunity for opponents to be heard, and the record is devoid of any indication that federal agency officials even considered the potential impact of the proposed plan on ERISA funds before approving the waiver. Under all of these circumstances, I cannot accept *amicus'* argument that the waiver effectively converted state law into federal law.

See, e.g., Vandemark, 663 F.2d at 441 ("[Local housing authority's] indebtedness policy was part of a policy submitted by the [authority] as part of its administrative plan which was approved by HUD . . . . However, the approval of the [authority's] policy did not establish a general policy which would bind all housing authorities and tenants . . . . The indebtedness policy is not, therefore, a policy of HUD but is rather a policy of the local housing authority").

I am also convinced that Congress would not approve the sort of patchwork pattern of laws affecting ERISA funds that would inevitably result if each state were to obtain a Medicare waiver and adopt its own variation of the NYPHRM. Multi-state ERISA funds such as that administered by plaintiff would then be placed in the awkward position of having to comply with the several states' differing provisions. Obviously, when viewed in light of the legislative history of ERISA's pre-emption provision with its heavy emphasis on interstate uniformity, such a result cannot be justified.[7]

As set forth above, I am not persuaded that Blue Cross is correct in its position that pre-emption of §2807-a.6(b) would result in the invalidation of the NYPHRM. If Blue Cross is correct, the result would, indeed, be unfortunate; I have reviewed the voluminous submissions detailing the need for reforms in New York's hospital reimbursement scheme, and I have been most impressed with the efforts devoted over many years to establishing this innovative and comprehensive alan. Nonetheless, this Court is bound to comply with express congressional intent to displace all state action in the field of private employee benefit programs and §2807-a.6(b) trenches upon that protected area. The Supreme Court recognized in *Shaw* that application of ERISA's pre-emption rules might well cause problems in the administration of New

York's fair employment laws. The Court concluded, however, that "those problems are the result of congressional choice and should be addressed by congressional action." 103 S.Ct. at 2904-5. The state has a similar remedy here.

For all of the reasons set forth above, I conclude that summary judgment for plaintiff is appropriate. Section 2807-a.6(b) of New York's Public Health Law is pre-empted insofar as it relates to ERISA funds, and enforcement against such funds is hereby enjoined.[8]

Plaintiff is instructed to submit a proposed judgment within five days of the date of this Opinion and Order, on five days' notice.

SO ORDERED.

s/ William C. Conner
United States District Judge

Dated: New York, New York
March 12, 1984

FOOTNOTES

1. Plaintiff's complaint asserts several causes of action in addition to the ERISA pre-emption claim. It alleges that §2807-a.6(b): (1) is pre empted by the Sherman Act, 15 U.S.C. §1 *et seq.;* (2) violates the Commerce, Contracts, and Supremacy Clauses of the United States Constitution; and (3) violates the Equal Protection Clause of the 14th Amendment. In hopes of obtaining a prompt disposition, plaintiff filed along with his complaint an order to show cause for entry of a preliminary injunction.

The Court set up a briefing schedule and granted permission for Blue Cross and Blue Shield of Greater New York to file an *amicus curiae* brief in opposition to a preliminary injunction. The parties and *amicus* thereafter addressed the likelihood of plaintiff's prevailing on the merits of his claim, as well as the irreparability of harm.

The Court made a preliminary review of the various submissions and concluded, at least with respect to the ERISA claim, that there were no factual issues to be resolved at a trial on the merits and a prompt resolution on the merits would be possible. A conference was convened on January 25, 1984, at which the parties and *amicus* were asked whether there would be any objection to the Court's treating the submissions as cross-motions for summary judgment on the ERISA claim and delaying resolution of the other claims. All interested parties indicated that this would be an appropriate manner in which to proceed because there were no disputed issues of material fact, and that they had no additional materials to submit.

2. The rate-setting procedure employed by the federal government is "retrospective." This means that "hospitals were issued rates estimated as adequate to cover their current costs for caring for Medicare patients and these rates were then subsequently retroactively adjusted to reflect the facilities' actual expenses." Sweeney Aff. at ¶7. According to Raymond Sweeney, the Director of the Office of Health Systems Management of the New York State Department of Health, this retrospective system was criticized because it provided no incentive to contain costs or increase efficiency. *Id.*

Under the "prospective" method adopted in New York, reimbursement rates are generally computed on the basis of actual expenditures in a previous "base year," and then adjusted for inflation. According to Sweeney, this system provides an incentive for hospitals to increase efficiency because they retain excess revenue generated by keeping actual per diem expenses below their per diem reimbursement rates. *Id.* at ¶6.

3. Defendants and *amicus* argue only that §2807-a.6(b) is saved from pre-emption by express exceptions to the broad rule of §514(a). Defendants assert that the "state is functioning here in an area [insurance regulation] in which it has primacy . . . . Accordingly, plaintiff's ERISA preemption claims must fail." Def's Mem. at p.11. Blue Cross states: "It is upon each of these express requirements — that ERISA not be construed to impair the discharge of other federal authority and that ERISA's pre-emption shall not apply to state laws regulating insurance — that plaintiff's ERISA claims founder. Mem. of *Amicus* at p.20.

4. This subsection is followed by a qualifying "deemer clause," §514(b)(2)(B), which provides that an employee benefit plan shall not "be deemed to be an insurance company or other

insurer . . . or to be engaged in the business of insurance or banking for purposes of any law of any State purporting to regulate insurance companies, insurance contracts, . . . or investment companies." Various courts and commentators have struggled to delineate the scope and explain the interaction of these subsections, particularly where legislation regulating aspects of insurance traditionally governed by the states has had an indirect or incidental impact on ERISA-covered plans. Their conclusions have not been consistent, and efforts to reconcile the varying interpretations have created still greater confusion. *See generally* Michigan United Food & Commercial Workers Union v. Baerwaldt, 572 F. Supp. 943 (E.D.Mich. 1983); Eversole v. Metropolitan Life Ins. Co., 500 F. Supp. 1162 (C.D.Cal. 1980); Manno, *ERISA Pre-emption and the McCarran-Ferguson Act: The Need For Congressional Action,* 52 Temple L.W. 51 (1979); Brummond, *Federal Pre-emption of State Insurance Regulation under ERISA,* 62 Iowa L.R. 57 (1976); *see also* American Progressive Life & Health Ins. Co. of New York v. Corcoran, 715 F.2d 184 (2d Cir. 1983). *But see* Attorney General v. Traveler's Insurance Co., 432 N.E. 433 2d 1223 (Mass. 1982), *vacated and remanded sub nom.,* Metropolitan Life Ins. Co. v. Massachusetts, ____ U.S. ____, 103 S.Ct. 3563 (1983). Fortunately, the present controversy does not present so delicate an issue. I conclude that §2807-a.6(b) does not "regulate insurance" within the meaning of §514(b)(2)(A), and therefore I find it unnecessary to join the fray.

5. The statute itself provides for some flexibility. Section 2807.10 provides:

> Notwithstanding the provisions of this article, the commissioner may waive, subject to the approval of the state director of the budget, the requirements

> of any provisions of this section *or section twenty-eight hundred seven-a* to permit the development and/or continuation of limited pilot reimbursement programs to provide additional knowledge and experience in different types of reimbursement mechanisms for general hospitals. (emphasis supplied).

6. *Amicus'* reliance on *Shaw* is misplaced because *Shaw* dealt with the impairment of Title VII of the Civil Rights Act of 1964, 42 U.S.C. §2000e *et seq.*, which is quite obviously a "law of the United States."

7. Indeed, the Court has been informed that prior to the enactment of the NYPHRM, the state received Medicare waivers from the federal government in order to establish two experimental reimbursement projects which operated at a regional level. Anderman Aff. at ¶5. It is conceivable, then, that ERISA plans would be subject to conflicting requirements *within* a given state.

8. Because §2807-a.6(b) is pre-empted by ERISA, I need not reach the other arguments raised by plaintiff.

ORDER OF JUDGMENT OF THE UNITED STATES DISTRICT COURT FOR THE SOUTHERN DISTRICT OF NEW YORK DATED MARCH 30, 1984

UNITED STATES DISTRICT COURT FOR THE
SOUTHERN DISTRICT OF NEW YORK

83 Civ. 8707
(WCC)

SEBASTIAN REBALDO, as Chairperson of the Board of Trustees of the UNITED OPTICAL WORKERS INSURANCE FUND,

Plaintiff,

-against-

MARIO CUOMO, GOVERNOR OF THE STATE OF NEW YORK; and DAVID AXELROD, COMMISSIONER OF HEALTH OF THE STATE OF NEW YORK,

Defendants.

This cause having come to be submitted before Hon. William C. Conner, United States District Judge, on plaintiff's motion for a preliminary injunction against New York Public Health Law §2807-a(6)(b) on the grounds that the state statute, in part, is pre-empted by §514(a) of the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. §1144(a), in part, conflicts with 15 U.S.C. §§1, 2, 13, 42 U.S.C. §1395ww, in part, violates the supremacy, commerce and contracts clauses of the United States Constitution and, in part, denies plaintiff equal protection of the laws under the Fourteenth Amendment to the United States Constitution; and the parties and the *amicus curiae*, Blue Cross

and Blue Shield of Greater New York, having consented to treating the motion for a preliminary injunction and the opposition thereto as cross-motions for summary judgment on plaintiff's claim that Public Health Law §2807-a(6)(b), in part, is pre-empted by ERISA, 29 U.S.C. 1144(a); and the court having considered the pleading, affidavits, exhibits, memoranda and letter-memoranda and having issues an opinion and order dated March 12, 1984; it is

ORDERED, ADJUDGED AND DECREED:

1. Plaintiff's motion for summary judgment is granted to the extent set forth in paragraphs 2 and 3 hereof, and defendants' motion for summary judgment is denied;

2. Public Health Law §2807-a(6)(b), in part, is declared pre-empted by ERISA, 29 U.S.C. §1144(a), and the state statute is invalid to the extent it prohibits a hospital from establishing inpatient charges for self-insured employee benefit plans covered by ERISA which are other than those authorized by Public Health Law §2807-a(6);

3. Defendants, their successors, officers and employees are enjoined from enforcing Public Health Law §2807-a(6)(b) to the extent the state statute prohibits a hospital from establishing inpatient charges for self-insured employee benefit plans covered by ERISA which are other than those authorized by Public Health Law §2807-a(6); . . .

Dated: New York, New York
March 30, 1984

Order

s/ William C. Conner
United States District Judge

Judgment Entered 3/30/84
s/ Raymond F. Burghardt
Clerk

ORDER OF THE UNITED STATES COURT OF APPEALS FOR THE SECOND CIRCUIT DATED NOVEMBER 26, 1984

UNITED STATES COURT OF APPEALS
FOR THE SECOND CIRCUIT

84-7388

At a stated Term of the United States Court of Appeals for the Second Circuit, held at the United States Courthouse in the City of New York on the twenty-six day of November one thousand nine hundred and eighty-four.

Present:

HON. HENRY J. FRIENDLY

HON. ELLSWORTH A. VAN GRAAFEILAND

HON. JON. O. NEWMAN
Circuit Judges,

SEBASTIAN REBALDO, as Chairperson of the Board of Trustees of the UNITED OPTICAL WORKERS INSURANCE FUND,

Plaintiff-Appellee,

v.

MARIO CUOMO, Governor of the State of New York; and DAVID AXELROD, Commissioner of Health of the State of New York,

Defendants-Appellants.

Order

Appeal from the United States District Court for the Southern District of New York.

This cause came on to be heard on the transcript of record from the United States District Court for the Southern District of New York and was argued by counsel.

ON CONSIDERATION WHEREOF, it is now hereby ordered, adjudged and decreed that the judgment of said District Court be and it hereby is vacated and the action be and it hereby is remanded to the said district court for further proceedings in accordance with the opinion of this court.

Elaine B. Goldsmith,
Clerk

s/ Edward J. Guardaro,
Deputy Clerk

A True Copy
Raymond F. Burghardt, Clerk

s/ J. Caffey
Deputy Clerk

RELEVANT STATUTES

State Statute

New York Public Health Law §2807-a(6) states in part:

Hospital charge schedules. Effective for the year beginning January first, nineteen hundred eighty four and thereafter, each general hospital shall establish a charge schedule for available and authorized services in accordance with a gross charge determination formula provided by the commissioner which shall:

(a) Establish gross charges sufficient to generate the inpatient revenue authorized by the revenue cap; and

(b) Establish gross charges such that (i) the payment rate to be made on behalf of subscribers of corporations organized and operating in accordance with article nine-C of the insurance laws, adjusted for uncovered services, shall be at a specified discount from the gross charge rate billed to or on behalf of charge paying patients; (ii) permit the continuation of negotiated payment rate determination systems between self-insured and self-administered groups and hospitals which were in effect on May first, nineteen hundred eighty-two; and (iii) for general hospitals subject to the provisions of paragraph (a) or (b) of subdivision twelve of this section [providing for article nine-c corporations and health maintenance organizations], the costs (including all allowances specified in subdivision four of this section) or services provided to charge paying patients shall be at a specified discount from the gross charge rate billed to or on behalf of charge paying patients.

During the period of January first, nineteen hundred eighty-four through December thirty-first nineteenth hundred ninety-five, the discount referred to in subparagraphs (i) and (iii) of paragraph

(b) of this subdivision shall not exceed twelve percent for those hospitals which had a discount of less than twelve percent during the previous year, shall be no greater than the discount in effect during the previous year for those hospitals whose previous year's discount was between twelve and fifteen percent and shall not exceed fifteen percent for all others. Self-insured and self-administered negotiated systems as described in subparagraph (ii) of paragraph (b) of this subdivision may remain in effect for the period commencing January first, nineteen hundred eighty-three and ending on December thirty-first, nineteen hundred eighty five and shall be incorporated in the formula methodology provided by the commissioner.

* * *

Federal Statute

§1144. Other laws

(a) Supersedure; effective date

Except as provided in subsection (b) of this section, the provisions of this subchapter and subchapter III of this chapter shall supersede any and all state laws insofar as they may now or hereafter relate to any employee benefit plan described in section 1003(a) of this title and not exempt under section 1003(b) of this title. This section shall take effect on January 1, 1975.

(b) Construction and application

* * *

(2)(A) Except as provided in subparagraph (B), nothing in this subchapter shall be construed to exempt or relieve any person

from any law of any State which regulates insurance, banking, or securities.

(B) Neither an employee benefit plan described in section 1003 (a) of this title, which is not exempt under section 1003(b) of this title (other than a plan established primarily for the purpose of providing death benefits), nor any trust established under such a plan, shall be deemed to be an insurance company or other insurer, bank, trust company. or investment company or to be engaged in the business of insurance or banking for purposes of any law of any State purporting to regulate insurance companies, insurance contracts, banks, trust companies, or investment companies.

(c) Definitions

For purposes of this section:

(1) The term "State law" includes all laws, decisions, rules, regulations, or other State action having the effect of law, of any State. A law of the United States applicable only to the District of Columbia shall be treated as a State law rather than a law of the United States.

(2) The term "State" includes a State, any political subdivisions thereof, or any agency or instrumentality of either, which purports to regulate, directly or indirectly, the terms and conditions of employee benefit plans covered by this subchapter.

(d) Alteration, amendment, modification, invalidation, impairment, or supersedure of any law of the United States prohibited

Relevant Statutes

Nothing in this subchapter shall be construed to alter, amend, modify, invalidate, impair, or supersede any law of the United States (except as provided in sections 1031 and 1137(c) of this title) or any rule or regulation issued under any such law.

(Pub. L. 93-406, Title I, §514, Sept. 2, 1974, 88 Stat. 897; Pub. L. 97-473, Title III, §§ 301(a), 302(b), Jan. 14, 1983, I 96 Stat. 2611, 2613.)

Office-Supreme Court, U.S.
FILED
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ALEXANDER L. STEVAS,
CLERK

No. 84-1347

IN THE

Supreme Court of the United States

OCTOBER TERM, 1984

SEBASTIAN REBALDO, AS CHAIRPERSON
OF THE BOARD OF TRUSTEES OF THE
UNITED OPTICAL WORKERS INSURANCE FUND,
Petitioner,

v.

MARIO CUOMO, GOVERNOR OF THE STATE OF NEW YORK;
and DAVID AXELROD, COMMISSIONER OF HEALTH
OF THE STATE OF NEW YORK,
Respondents.

On Writ of Certiorari to the United States Court of Appeals For the Second Circuit

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BRIEF *AMICUS CURIAE* OF LOCAL 338 HEALTH AND WELFARE FUND AND LOCAL 814 WELFARE FUND

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IN THE

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OCTOBER TERM, 1984

No. 84-1347

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and DAVID AXELROD, COMMISSIONER OF HEALTH
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Respondents.

On Writ of Certiorari to the United States Court of Appeals For the Second Circuit

---

BRIEF *AMICUS CURIAE* OF LOCAL 338 HEALTH AND WELFARE FUND AND LOCAL 814 WELFARE FUND

INTEREST OF THE *AMICI*

The Trustees of the Local 338 Health and Welfare Fund and the Local 814 Welfare Fund submit this brief with the written consent of the parties pursuant to Supreme Court Rule 36.1.

The Local 338 Health and Welfare Fund and the Local 814 Welfare Fund ("the Funds") are employee welfare benefit plans within the meaning of Section 3(1) of the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. § 1002(1). The Funds provide a wide variety of health and hospitalization benefits to more than 20,000 participants and their families residing in New York, New Jersey, California, Florida, Virginia, Pennsylvania and Connecticut. These benefits are funded exclusively by employer contributions made pursuant to collective bargaining agreements between various employers and Local 338 Retail, Wholesale and Department Store Union, in the case of the Local 338 Health and Welfare Fund, and Local 814, International Brotherhood of Teamsters, in the case of the Local 814 Welfare Fund.

Since its inception in 1941, the Local 338 Health and Welfare Fund has acted as its own insurer of the health benefits it provides to the individuals it covers. Hospitalization benefits provided by the Local 814 Welfare Fund are insured by Blue Cross-Blue Shield of Greater New York, Inc. ("Blue Cross"), a non-profit health service corporation operated under the requirements of Article 43 of the New York Insurance Law. N.Y. Ins. Law §§ 4301-15 (McKinney Supp. 1984) ("Article 43"). The Trustees of the Local 814 Welfare Fund are presently considering self-insurance of hospital benefits because they are dissatisfied with the excessive cost and benefit program requirements of insuring benefits through Blue Cross.

Amici are vitally concerned that the freedom to determine the method by which benefits are insured, and the freedom to decide the nature of the benefits which they provide, both of which are protected by ERISA, not be infringed by any States' legislation. If the decision of the Court of Appeals in this case is upheld it will deprive *Amici* of their right to determine the Funds' structure and benefits free of interference by the State.

STATEMENT OF THE CASE

This case presents the question whether a state statute which financially penalizes welfare plans for making choices relating directly to plan design can survive ERISA's far-reaching preemption of all state laws which "relate to" employee benefit plans. ERISA § 514(a), 29 U.S.C. § 1144(a). New York's Public Health Law 2807-a (6)(b), N.Y. Pub. Health Law § 2807-a(6)(b) (McKinney Supp. 1984-85) ("§ 2807-a(6)(b)"), clearly "relates to" welfare benefit plans because its purpose and effect are to discourage self-insurance by welfare plans and to encourage insurance of benefits through insurers which are mandated by law to provide specific benefits.

A. The Choice Between Self-Insurance and Third Party Coverage.

The benefits provided by an employee welfare benefit plan may be insured by the fund itself, or by an outside commercial or non-profit carrier. ERISA places the burden of this decision with the trustees of a plan. Their choice must be made "in the interest of the participants and beneficiaries and . . . for the exclusive purpose . . . of providing benefits to participants and beneficiaries . . . ." ERISA § 404(a)(1)(A)(i), 29 U.S.C. § 1104 (a)(1)(A)(i).

One of the major reasons that plan trustees have traditionally chosen to insure benefits with health service corporations such as Blue Cross is administrative. The insurer will assume the burden of the plan's day-to-day administration of claims.

A variety of reasons have supported the decision to self-insure. Enormous savings are associated with self-insurance. Funds which self-insure can institute and closely oversee cost and quality control programs. In addition, administrative costs of the plan are often halved by self-insurance. Thirdly, interest earned by the amounts which would be pre-paid to insurers as reserves

are kept by the self-insured fund. These savings made possible by self-insurance permit plans to offer participants broader and better coverage for their health needs. Self-insurance also affects the nature of benefits which a fund may provide. It permits complete flexibility relating to substantive benefits. These factors which inform a plan's decision to self-insure unequivocally establish that the *means* of benefit insurance chosen is an integral aspect of plan design affecting funding and substantive benefits.

B. The Effect of New York Public Health Law Section 2807-a(6)(b).

Section 2807-a(6)(b) of the New York Public Health Law poses a two-prong threat to the right of plan trustees to freely determine plan design. The provision first prohibits negotiation of discount charges for hospital care.[1] Such direct negotiation with hospitals had been a traditional means of non-profit insurers and self-insured groups to obtain lower costs for hospital care for their subscribers.

At the same time that the statute bans the negotiation of discounts, it automatically bestows a discount upon insurers organized and operating under Article 43 of the New York Insurance Law.[2] It is the only discount permitted under the law. Upon the effective date of Section 2807-a(6)(b), nearly all discount arrangements by self-insured and self-administered groups must be cancelled, and by the end of 1985, all must be terminated. The statute permits the temporary continuation of discounts negotiated by self-insured and self-administered groups

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[1] The prohibition by Section 2807-a(6)(b) of discount rate negotiation is imbedded within a mandate to the State's general hospitals to establish a schedule of gross charges for service sufficient to generate the revenue necessary for efficient operation.

[2] Section 2807-a(6)(b) refers to "corporations organized . . . in accordance with article nine-C of the Insurance law." Article nine-C has been recodified as Article 43.

which had already been in effect on May 1, 1982. All discounts to self-insured and self-administered groups must be terminated before January 1, 1985. By contrast, Article 43 insurers are automatically granted a rate discounted by twelve to fifteen percent. As a direct result, Section 2807-a(6)(b) creates a financial incentive to welfare plans to insure hospital benefits through an Article 43 corporation like Blue Cross. Welfare plans that decide that plan participants' needs are better served by self-insurance will pay twelve to fifteen percent more for the identical hospital care.

C. State Law Controls on Article 43 Insurers.

Article 43 of New York Insurance Law governs the organization and operation of non-profit medical and dental indemnity corporations and health or hospital service corporations. Blue Cross, the insurer of Local 814 Welfare Fund's hospitalization benefits, is a non-profit health service corporation as defined by § 4301(e) of the New York Insurance Law. Article 43 primarily regulates the internal structure and governance of non-profit insurers and sets out requirements relating to their operation as fair and sound insurers.

In addition to the regulation of the structure of non-profit insurers, Article 43 mandates the provision of numerous substantive benefits. Section 4303(a) provides that every contract issued by a health service corporation which provides coverage for in-patient care must also provide coverage for pre-admission/pre-surgical testing, emergency medical services, and home care. N.Y. Ins. Law § 4303(a). Section 4303(b) requires health service corporations which provide surgical coverage to provide coverage for second surgical opinions.[3] N.Y. Ins. Law § 4303(b). Health service corporation contracts

[3] Section 4303(a) and (b) do not apply to group contracts covering individuals employed in more than one state, or to group contracts whose benefit structure was the subject of collective bargaining affecting persons who are employed in more than one state. N.Y. Ins. Law § 4303(a)(3)(D).

which cover in-patient hospital service must also include coverage for pre-natal and maternity care.[4] N.Y. Ins. Law § 4303(c). Article 43 also imposes restrictions on the patients which may be excluded from coverage under group contracts.[5]

The effect of Section 2807-a(6)(b) is therefore not restricted to discouraging plans from acting as their own insurers of benefits. The statute, by pushing plans into the arms of Article 43 insurers, also forces these plans to provide the substantive benefits which Article 43 corporation contracts must provide.[6]

The combined effect of Section 2807-a(6)(b) and Article 43 is to encourage plans to insure benefits with an Article 43 insurer, and to provide the benefits which the New York State Legislature has deemed valuable. Section 2807-a(6)(b) thus places an impermissible burden on the exercise of the right to self-insure and determine substantive plan design.

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[4] Nursing home care, ambulatory care and the diagnosis of emotional disorders must also be made available under contracts for inpatient hospital care. N.Y. Ins. Law §§ 4303(d), (e) and (g) (respectively). Health service corporation contracts which cover medical, surgical or major medical care must make available coverage for children's preventive and primary care. N.Y. Ins. Law § 4303(j). Alcoholism and alcohol abuse diagnosis and treatment must be made available by health service corporation contracts which provide group, group remittance or school blanket coverage for inpatient and hospital care. N.Y. Ins. Law § 4303(k).

[5] Section 4305(c)(1) provides that group contracts which cover a member's spouse and dependents but terminate dependents' coverage upon their attainment of a certain age must not terminate coverage of dependent unmarried children who are incapable of self-sustaining employment because of an emotional or physical handicap or illness.

[6] Plans whose hospitalization benefits are insured by an Article 43 corporation cannot elect a contract with that corporation that does not cover the benefits which Article 43 requires. As it would violate the fiduciary duty the plan's trustees owe to participants to deny coverage which the plan has purchased, such coverage must be provided to the participants.

ARGUMENT

NEW YORK PUBLIC HEALTH LAW SECTION 2807-a(6)(b) IS PRE-EMPTED BY THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974.

Section 2807-a(6)(b) of the New York Public Health Law denies self-insured employee benefit plans the vital right to negotiate discount rates with hospitals. By extinguishing this right, while at the same time affording Article 43 corporations such as Blue Cross a twelve to fifteen percent discount, Section 2807-a(6)(b) impermissibly puts self-insured employee benefit plans to a Hobson's choice: such plans must either significantly reduce their benefits so as to be able to afford the non-discounted rate, or forego their self-insured status in order to take advantage of the discount offered to Article 43 insurers such as Blue Cross. If the latter choice is made, the plans are effectively forced to offer their beneficiaries the statutorily prescribed benefits Article 43 insurers must offer.

In stark contrast to New York State's attempt to influence whether plans self-insure or insure, and what benefits they offer, ERISA places questions of plan structure and design within the sole discretion of the plan trustees. With respect to plan structure, the trustees are free to decide whether to structure a plan on an insured or self-insured basis. 29 U.S.C. § 1002(1). They are also vested with the authority to determine what benefits a plan provides, free of governmental influence and control.

Section 2807-a(6)(b) thus impermissibly attempts to regulate matters which Congress expressly left to the discretion of plan trustees. In spite of this, and in spite of the self-evident impact of Section 2807-a(6)(b) on self-insured welfare benefit plans, the court below concluded that the statute did not "relate to" employee benefit plans within the meaning of Section 514(a) of ERISA. *Rebaldo* v. *Cuomo*, 749 F.2d 133, 137-38 (2d Cir. 1984).

This conclusion directly conflicts with this Court's decisions in *Shaw* v. *Delta Air Lines, Inc.*, —— U.S. ——, 103 S.Ct. 2890 (1983) and *Alessi* v. *Raybestos-Manhattan, Inc.*, 451 U.S. 504 (1981). It also ignores the plain language, legislative history and purpose of ERISA Section 514(a). 29 U.S.C. § 1144(a). Accordingly, this Court should grant the petition for a writ of *certiorari* and reverse the decision of the court below.

A. Section 2807-a(6)(b) Impermissibly Dictates The Benefit Packages Which Employee Welfare Benefit Plans Must Offer.

In *Shaw* v. *Delta Air Lines*, —— U.S. ——, 103 S.Ct. 2890, this Court established the fundamental proposition that ERISA pre-empts all laws which directly or indirectly require employee benefit plans to provide a certain kind of benefit. The laws at issue in *Shaw* were New York's Disability Benefits Law and New York's Human Rights Law. These laws, respectively, required employers to pay to their employees sick-leave benefits during pregnancy leaves and prohibited employee benefit plans from treating pregnancy differently from other disabilities.

After a thorough examination of the language and legislative history of ERISA's pre-emption clause, this Court declared that it had "no difficulty in concluding" that laws which require or prohibit the provision of specific benefits "relate to" employee benefit plans within the meaning of ERISA. *Shaw*, 103 S.Ct. at 2899. Thus, absent an express statutory exemption from pre-emption,[7] such laws are pre-empted by ERISA. *Id.*

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[7] The only state laws exempt from Section 514(a) pre-emption are those regulating insurance, banking or securities. 29 U.S.C. § 1144(b)(2)(A), and generally applicable criminal laws. 29 U.S.C. § 1144(b)(4). Additionally, state laws which relate to employee benefit plans that are not within ERISA's coverage are exempt from pre-emption. 29 U.S.C. § 1003(b).

In accordance with *Shaw*, the lower federal courts have overwhelmingly concluded that any state law which requires or prohibits the provision of certain benefits to certain participants is within the broad pre-emptive reach of Section 514(a).[8] *See, e.g., Champion International Corp.* v. *Brown*, 731 F.2d 1406 (9th Cir. 1984); *Stone & Webster Engineering Corp.* v. *Ilsley*, 690 F.2d 323 (2d Cir. 1982), *aff'd sub nom. Arcurdi* v. *Stone & Webster Engineering Corp.*, —— U.S. ——, 103 S.Ct. 3564 (1983). *Standard Oil Co.* v. *Agsalud*, 633 F.2d 760 (9th Cir. 1980); *aff'd mem.*, 454 U.S. 801 (1981); *Hewlett-Packard Co.* v. *Barnes*, 571 F.2d 502 (9th Cir.), *cert. denied*, 439 U.S. 831 (1978); *Michigan United Food & Commercial Workers Union* v. *Baerwaldt*, 572 F. Supp. 943 (E.D. Mich. 1983); *California Hospital Association* v. *Henning*, 569 F. Supp. 1544 (D.C. Cal. 1983); *Blue Cross and Blue Shield of Alabama* v. *Peacock's Apothecary, Inc.*, 567 F. Supp. 1258 (N.D. Ala. 1983); *Dawson* v. *Whaland*, 529 F. Supp. 626 (D.N.H. 1982).

Section 2807-a(6)(b), although part of a hospital cost containment law, is precisely the type of mandated benefit statute which this Court and the lower federal courts have held to be pre-empted by ERISA. Section 2807-a(6)(b), by granting Article 43 insurers such as Blue Cross a statutory discount rate while simultaneously denying self-insured plans the right to negotiate discounts, forces self-insured plans to choose between significantly reducing the benefits they now provide or switching to an Article 43 insurer such as Blue Cross. If the latter is chosen, the plans must provide the statutorily prescribed benefits which Article 43 mandates. *See* N.Y. Ins. Law § 4303. Section 2807-a(6)(b) thus creates an overriding economic incentive to provide only those benefits which New York State deems valuable.

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[8] This issue is currently being considered by this Court in *Attorney General* v. *Travelers Insurance Co.*, 391 Mass. 730, 463 N.E. 2d 548, *prob. juris. noted, sub nom. Metropolitan Life Insurance Co.* v. *Massachusetts*, —— U.S. ——, 105 S.Ct. 320 (1984).

That Section 2807-a(6)(b) seeks to accomplish indirectly, by legislative sanctions and incentives, what the New York State laws in *Shaw* sought to accomplish directly, by legislative mandate, is of no importance. ERISA Section 514(a) pre-empts laws of a "State," which ERISA Section 514(c)(2) defines as an instrumentality "which purports to regulate, *directly or indirectly*, the terms and conditions of employee benefit plans." 29 U.S.C. § 1144(c)(2) (emphasis added). As this Court explained in *Alessi* v. *Raybestos-Manhattan, Inc.*, 451 U.S. 504, after holding that New Jersey's workers' compensation law was pre-empted by ERISA:

> It is of no moment that New Jersey intrudes indirectly, through a workers' compensation law, rather than directly, through a statute called "pension regulation." ERISA makes clear that even indirect state action bearing on private pensions may encroach upon the area of exclusive federal concern . . . . ERISA's authors clearly meant to preclude the states from avoiding through form the substance of the pre-emption provision.

Id. at 525. Thus, New York may not, through economic sanctions and incentives in a hospital cost containment statute, attempt to mandate the benefits which employee benefit plans provide.

B. Section 2807-a(6)(b) Impermissibly Intrudes Upon The Decision Of Employee Benefit Plans To Be Structured On A Self-Insured Basis.

Section 2807-a(6)(b) creates a compelling economic incentive for employee benefit plans to forego their self-insured status. It thus runs directly counter to ERISA, which allows plan trustees to decide free from governmental interference whether to insure or self-insure. *See* 29 U.S.C. § 1002(1).

In *Alessi* v. *Raybestos-Manhattan, Inc.*, 451 U.S. 504, this Court struck down a state statute which, like Section

2807-a(6)(b), attempted to prohibit an trustees from doing that which ERISA allowed them to do. *Alessi* involved a New Jersey statute that prohibited pension plans from offsetting workers' compensation benefits against employee retirement benefits. Holding that the statute was pre-empted by ERISA, this Court concluded that the statute " 'relate[s] to pension plans governed by ERISA because it eliminates one method for calculating pension benefits—integration—that is permitted by federal law." *Alessi*, 451 U.S. at 524.

In reaching this conclusion, this Court acknowledged that "ERISA does not mention integration with workers' compensation . . ." *Id.* at 517. Nonetheless, because integration was implicitly permitted by federal law, and because Congress meant to establish employee benefit plan regulation as "exclusively a federal concern," *id.* at 523, the state law was held to be pre-empted.

It is immaterial that New York State, in Section 2807-a(6)(b), is attempting to regulate by economic sanction and coercion rather than, as in *Alessi*, by outright prohibition. In both cases, the States are impermissibly encroaching upon an area which Congress left to the sole discretion of plan trustees. Moreover, because ERISA explicitly allows funds to self-insure, this case represents an even more direct conflict with federal law than was the case in *Alessi*, where ERISA did not explicitly permit that which the state ought to outlaw. Accordingly, under the principles of *Alessi*, Section 2807-a(6)(b) must be held to be pre-empted.

C. Section 2807-a(6)(b) "Relates To" Employee Benefit Plans And Is Not Remote, Tenuous Or Peripheral To ERISA.

This Court has made clear that a law "relates to" an employee benefit plan within the meaning of Section 514(a) "if it has a connection with or reference to such a plan." *Shaw*, 103 S.Ct. at 2900. Section 2807-a(6)(b)'s

"connection with" self-insured employee benefit plans is manifest. Section 2807-a(6)(b) creates an economic compulsion for plans to forego their self-insured status and switch to coverage by an Article 43 insurer. By so doing, the statute forces these plans to abandon the benefit packages they now provide and adopt those which Article 43 insurers are required by statute to offer. A more direct "connection" is difficult to envision.

Section 2807-a(6)(b) also explicitly "refers to" employee benefit plans within the meaning of ERISA Section 514(a). Section 2807-a(6)(b), after granting Article 43 corporations such as Blue Cross a mandatory discount rate, immediately prohibits certain "self-insured and self-administered groups" from negotiating discount rates with hospitals. Other "self-insured and self-administered groups" are permitted to rely on their negotiated discount rate until December 31, 1985, at which time all negotiated rates will be disallowed. The law on its face thus regulates a critical aspect of how employee benefit plans function. This direct intrusion is precisely the type of regulation which Congress, in enacting ERISA Section 514(a), sought to prevent.

The court below attempted to circumvent these principles by holding that Section 2807-a(6)(b) was remote, tenuous and peripheral to ERISA. In so holding, the court determined that Section 2807-a(6)(b) merely affected a plan's "cost of doing business." *Rebaldo* v. *Cuomo*, 749 F.2d at 138-39. This conclusion is simply unsupportable.

Section 2807-a(6)(b) establishes economic sanctions and incentives which effectively dictate whether a plan may continue to operate on a self-insured basis. As stated, Section 2807-a(6)(b) requires self-insured plans to either drastically reduce the benefit packages they now offer or switch to an Article 43 insurer such as Blue Cross. If the latter choice is made, plans must provide

the benefits which Article 43 mandates and, in certain instances, cover certain persons who otherwise might not be covered. *See* N.Y. Ins. Law § 4305(c)(1) and note 5, *supra* at 6. Such a fundamental encroachment upon a plan's structure and functioning can hardly be characterized as a "mere cost of doing business."

The regulation at issue here bears little resemblance to that involved in *American Telephone & Telegraph Co.* v. *Merry*, 592 F.2d 118 (2d Cir. 1979). At issue in *Merry* was a state court judgment which ordered the garnishment of one person's pension income in order to enforce alimony and support obligations. 592 F.2d at 120. Thus, *Merry* involved the " 'ancient family law right' of maintenance and support," 592 F.2d at 122, which has always been treated "different[ly] from other laws." *Stone* v. *Stone*, 450 F. Supp. 919 (N.D. Cal. 1978), *aff'd*, 632 F.2d 740 (9th Cir. 1980), *cert. denied*, 453 U.S. 922 (1981). *See generally Savings & Profit Sharing Fund of Sears Employees* v. *Gago*, 717 F.2d 1038 (7th Cir. 1983); *Operating Engineers Local 428 Pension Trust Fund* v. *Zamborsky*, 650 F.2d 196 (9th Cir. 1981).

More importantly, the garnishment of one member's benefits, at issue in *Merry*, is fundamentally different from the legislation at issue here. The former, while perhaps generating some incidental administrative expenses to a plan, does not touch upon a plan's structure, administration and benefit package.[9] The latter, by at-

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[9] To the same effect is Lane v. Goren, 743 F.2d 1337 (9th Cir. 1984), another case on which the court below erroneously relied. The Ninth Circuit in *Lane* held that a California statute which prohibited an employee benefit plan acting as an employer from discriminating against the plan's own employees was not pre-empted. 743 F.2d at 1338. The statute did not purport to regulate the plan's structure or functioning as an employee benefit plan. Furthermore, prior to *Lane*, this Court in *Shaw* had explicitly stated that a law "prohibit[ing] employment discrimination in hiring, promotion, salary and the like" would not be pre-empted. 103 S.Ct. at 2900 n.17.

tempting to dictate how a plan is structured and what benefits it provides, is precisely the type of regulation of a plan *qua* plan which Congress explicitly pre-empted in ERISA Section 514(a).

D. In Giving Controlling Weight To New York's Interest In Hospital Cost Containment, The Court Below Stood The Legislative History And Purpose Of ERISA Section 514(a) On Its Head.

Recognizing that "[t]he breadth of § 514(a)'s pre-emptive reach is apparent from that Section's language," *Shaw*, 103 S.Ct. at 2899-90, this Court has characterized ERISA's expansive pre-emption clause as "virtually unique." *Franchise Tax Board of California* v. *Construction Laborers Vacation Trust for Southern California*, —— U.S. ——, 103 S.Ct. 2841, 2854 n.26 (1983). Indeed, unlike any other federal legislation, except for the narrow exceptions specified in the Act, the pre-emption of state laws which relate in any way to employee benefit plans is total.

The legislative history of Section 514(a) demonstrates that Congress deliberately employed the broadest possible language in order to occupy the field of employee benefit plan regulation. Congress enacted ERISA in response to a clearly perceived need for uniform, federal regulation of employee benefit plans. *See Shaw*, 103 S.Ct. at 2901; *Alessi*, 451 U.S. at 523. It determined that in order to remove the problem of increasingly intrusive and inconsistent state laws,[10] ERISA should fully displace state laws with a uniform body of federal law. Accordingly, Congress rejected earlier versions of a bill containing a

[10] Section 2807-a(6)(b) is precisely the type of intrusive state law which Congress sought to preempt. Among the plans affected by Section 2807-a(6)(b) are those, like the *Amici*, which are multi-state in scope. Requiring the plans here to forego self-insurance and switch to Blue Cross in New York would have a devastating effect on the plans' ability to self-insure in the other states in which their members live.

pre-emption clause which only displaced state laws relating to the specific subjects covered by ERISA. *Shaw*, 103 S.Ct. at 2900-01. Instead, it enacted a bill which, with the narrow statutory exceptions discussed above, sweepingly displaced state laws that in any way touched upon employee benefit plans. *Id.*

The decision below stands the legislative purpose of ERISA section 514(a) on its head by making the significance of the state interest at stake the touchstone of its analysis. The court below, throughout its decision, gave controlling weight to New York State's interest in hospital cost containment. By so doing, it ignored the fact that Section 514 pre-empts *all* state laws relating to employees benefit plans except for those specifically exempted. Hospital cost containment laws, however important, are nowhere on the statutory list of exemptions.

The impropriety of weighing the state interest at stake here becomes apparent upon an examination of this Court's decision in *Shaw*. New York's interest in eliminating sex discrimination, at issue in *Shaw*, is surely as important as its interest in hospital cost containment. In fact, the former interest, which is of constitutional dimension, is probably more weighty than the latter, which is merely an economic one. Nonetheless, this Court in *Shaw* refused to disturb the explicit federal-state accommodation struck by Congress in Section 514 by engaging in a balancing act. The court below should not be permitted to do so here.

CONCLUSION

For all of the foregoing reasons, the petition for a writ of *certiorari* should be granted.

Respectfully submitted,

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IN THE

Supreme Court of the United States

OCTOBER TERM, 1984

SEBASTIAN REBALDO, as CHAIRPERSON OF THE BOARD OF TRUSTEES OF THE UNITED OPTICAL WORKERS INSURANCE FUND,
Petitioner,

vs.

MARIO CUOMO, GOVERNOR OF THE STATE OF NEW YORK; and DAVID AXELROD, COMMISSIONER OF HEALTH OF THE STATE OF NEW YORK,
Respondents.

On Petition for a Writ of Certiorari to the United States Court of Appeals for the Second Circuit

BRIEF OF AMICUS CURIAE CENTRAL STATES, SOUTHEAST AND SOUTHWEST AREAS HEALTH AND WELFARE FUND

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BRIEF OF AMICUS CURIAE CENTRAL STATES, SOUTHEAST AND SOUTHWEST AREAS HEALTH AND WELFARE FUND

INTRODUCTION

The petition for certiorari raises an important issue: whether the Employee Retirement Income Security Act of 1974 ("ERISA") preempts "a state statute that prohibits the continuation or negotiation of discount rate agreements between self-insured employee benefit plans and hospitals . . . ." The Second Circuit ruled against federal supremacy, upholding the state statute in an opinion reported at 749 F.2d 133. The Central States, Southeast and Southwest Areas Health and Welfare Fund ("Central States"), appearing as *amicus curiae* with the

consent of all parties (*see* Appendix), respectfully requests this Court to grant the petition and reverse the decision below. That decision, if left standing, will erode the federally-protected right of employee welfare plans to self-insure their participants' medical benefits, and will subject those plans to the vagaries of state-by-state regulation that ERISA was designed to preclude.

The state statute at issue is N.Y. Pub. Health Law §2807-a, which deals with hospital charges. Enacted as a cost-containment measure, it directs state officials to "cap," in dollars, each general hospital's annual revenue for in-patient services (§ 2807-a(1)), and directs the hospitals to set their rates so as to generate revenue equal to the "cap" amount (*id.* at -a(6)(a)). The statute establishes two different categories of rates: one for Medicare, Medicaid and state-regulated corporations such as Blue Cross; and a second for other payors including self-insured employee welfare benefit plans. The rates in the second category are 12-15% higher than those in the prime category; to enforce the differential, the statute prohibits hospitals from negotiating discounts with "self-insured and self-administered" employee benefit plans. § 2807-a(6)(b).

The United Optical Workers Insurance Fund, on whose behalf this case was filed, is an employee welfare benefit plan covered by ERISA. For many years the Optical Workers Fund had provided hospital benefits for its members by purchasing Blue Cross insurance. In 1983, beset by rising premiums, the Fund chose to self-insure those benefits. Then, as a direct purchaser of hospital services, the Fund began to negotiate favorable discount rates with individual hospitals, thereby reducing its costs while maintaining benefit levels.

When N.Y. Pub. Health Law § 2807-a outlawed its hospital contracts, the Fund sued to prevent enforcement of the statute on the ground that ERISA had preempted the field. The Fund argued that Congress decided in 1974 that employee benefit plans, many of which operate nationwide, would prosper best under uniform national regulation. Toward that end, ERISA was drafted so as to supersede state laws that "relate to" any welfare benefit plan. The district court ruled in favor of

the Fund, but the Second Circuit reversed. The appellate court held that the language of ERISA did not lead to the "unavoidable conclusion" that Congress had preempted the regulation of hospital rates paid by welfare benefit plans. As a result, the court stated, the federal law allowed New York to outlaw the plans' competitive rate negotiations and to compel self-insured plans to pay substantially higher hospital charges than Blue Cross.

INTEREST OF THE AMICUS CURIAE

Central States, one of the nation's largest employee welfare benefit plans, was established to aid members of the International Brotherhood of Teamsters, Chauffeurs, Warehousemen and Helpers of America. The plan's 150,000 participants are located throughout 34 states.[1]

The Central States welfare plan exists solely to provide medical and other benefits to its participants and their dependents. The plan is funded by employer contributions pursuant to collectively bargained agreements with local affiliates of the International Union. During 1983, Central States used those funds to provide its members with some $350 million in benefits.

At the present time, Central States is almost entirely self-insured: *i.e.*, it pays most medical claims directly out of its own trust funds. Central States has found self-insurance to be cheaper and more efficient than the alternative of purchasing policies from commercial insurers or Blue Cross. Self-insurance has enabled Central States to cope with today's spiraling health care costs by directly negotiating hospital contracts similar to those abrogated by the New York statute. Those arrangements introduce an important element of competition into the health care field while allowing Central States to obtain the best available care for its members at competitive, reasonable prices.

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[1] The pension benefits of Teamsters' retirees are administered by the Central States, Southeast and Southwest Areas Pension Fund, a sister organization of the *amicus curiae*. The pension fund serves 400,000 participants and retirees in all 50 states.

Self-insurance is not a commercially viable option for an employee benefit plan unless the plan retains the right to negotiate the rates it is committed to pay hospitals and other health care providers. Otherwise, self-insurance could result in financial disaster. As a large self-insurer, Central States is directly affected by the rationale of the Second Circuit's decision that the states may regulate the hospital charges paid by employee benefit plans, and burden self-insured plans with significantly higher rates than those paid by Blue Cross.

By permitting New York to set fixed rate-differentials between Blue Cross and self-insured welfare benefit plans, the Second Circuit has turned over to the states the power to drive the self-insured plans out of business. For example, under the rationale of the decision below, ERISA would not supersede a state statute that forced self-insured plans to pay hospital rates 50% higher than those of Blue Cross, requiring the plans to severely reduce benefits, or to pay rates 50% lower, making contracts with the plans economically unattractive to the hospitals. Regardless of how it might be exercised, the power to fix the price at which self-insured plans are compelled to buy health care services is the power to eliminate self-insurance as a benefit plan option. In addition, the combined effect of numerous, and potentially inconsistent, state regulations in this field would spell the end of the federal uniformity envisioned by Congress with the passage of ERISA.[2]

This Court's resolution of the important issue of federal supremacy raised by the decision below will determine whether the states may indirectly control the benefits afforded by self-

[2] New York is not the only state which has chosen to legislate in this field. *See, e.g., Blue Cross & Blue Shield of Alabama v. Peacock's Apothecary, Inc.*, 567 F. Supp. 1258 (N.D. Ala. 1983). There, an Alabama statute prohibited agreements between third-party payors and pharmacies establishing reimbursement rates that were "less than the usual and customary rates paid by consumers not covered by a third-party plan for the same or similar services." Ala. Code § 34-23-115. The court held that "[a]lthough the Act directly regulates [only] the agreements and relationships between insurers and pharmacies, it effectively regulates what employers and employees can and cannot include in employee benefit plans." The Act therefore "related to" ERISA benefit plans and was preempted. 567 F. Supp. at 1276.

insured welfare plans by fixing the price they must pay for the medical benefits they provide. Because the inescapable effect of the Second Circuit's decision will be to force self-insured plans to reduce benefits or abandon self-insurance, the outcome is of great significance to the millions of American workers whose families rely on employee welfare benefit plans for their health care.

REASONS FOR GRANTING THE WRIT

ERISA, 29 U.S.C. § 1001 *et seq.*, is a comprehensive federal statute designed to protect the interests of the country's employees and their beneficiaries in employer-funded benefit plans. ERISA-protected plans provide either retirement income (pension plans) or medical, disability and other benefits (welfare plans). *See* 29 U.S.C. § 1002(1)-(3). ERISA has codified various uniform standards for these plans, including reporting, disclosure, and fiduciary responsibility regulations. *See* 29 U.S.C. §§ 1021-31, 1101-14.

Congress, by enacting ERISA, "meant to establish [employee benefit] plan regulation as exclusively a federal concern." *Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504, 523 (1981). Toward that end, Congress inserted an expansive preemption provision into the statute: ERISA § 514(a) provides that the Act "shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan" covered by ERISA. 29 U.S.C. § 1144(a).

This Court first interpreted § 514(a) in the *Alessi* case, where it invalidated a section of the New Jersey Workers' Compensation Act that prohibited pension plans from reducing, or offsetting, retiree benefits by the amount of workers' compensation awards received after retirement. Noting that Congress had been aware of this offset practice (called integration) when it enacted ERISA (451 U.S. at 521), the Court unani-

mously ruled that the New Jersey statute "relate[d] to" employee benefit plans "because it eliminate[d] one method for calculating pension benefits—integration—that is permitted by federal law." 451 U.S. at 524.[3]

The decision below cannot be squared with *Alessi*. The challenged provisions of New York's Public Health Law equally "relate to" employee benefit plans because they effectively eliminate one method for securing benefits—self-insurance—that is permitted by ERISA. It is indisputable that ERISA covers self-insured plans, and that in 1974 Congress was aware of and approved the concept of benefit plans acting as self-insurers. Indeed, ERISA § 3(a), 29 U.S.C. § 1002(1), defines a welfare benefit plan as a plan or fund established to provide medical or other benefits "through the purchase of insurance *or otherwise.*" (Emphasis added.) Self-insurance is comprehended within the "otherwise" category; when ERISA was enacted, as now, the benefits of employee welfare plans were secured in two main ways: by contracts with commercial insurance carriers, and by the plans' trust assets.

Congress' recognition of this dichotomy is reflected in ERISA's reporting and other requirements as well as in the legislative history. *See, e.g.*, § 103(e), 29 U.S.C. § 1023(e), which requires that specified information be included in a plan's annual report if any benefits are provided through the purchase of insurance, and § 403(b)(1), 29 U.S.C. § 1103(b)(1), which exempts insurance policies from the requirement that all plan assets be held in trust. *See also* H.R. Conf. Rep. No. 1280, 93d Cong., 2d Sess. 257, 296-99, 305 (1974), *reprinted in* Subcommittee on Labor, Senate Committee on Labor and Public Welfare, 3 Legislative History of ERISA 4524, 4563-66, 4572 (1976); 29 C.F.R. § 2560.503-1(c), (f), (g)(2); § 2550.403b-1(a)(1); § 2520.102-3(e); § 2520.104-44. These regulations would be meaningless unless self-insurance is a welfare benefit plan option preserved by ERISA. New York's attempt to regulate the terms on which

[3] In reaching that result, the Court considered it insignificant that New Jersey had intruded upon the federal statutory scheme indirectly, through a workers' compensation law, rather than directly, through a pension regulation enactment. As the Court stated, "ERISA's authors clearly meant to preclude the states from avoiding through form the substance of the pre-emption provision." *Id.* at 525.

self-insured plans may contract with hospitals is therefore "an impermissible intrusion on the federal regulatory scheme." *Alessi*, 451 U.S. at 525.

The Second Circuit, in its attempt to avoid the federal supremacy judgment that logically follows from the *Alessi* analysis, committed a second significant error : it misapplied the ERISA preemption criteria adopted by this Court in *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 103 S.Ct. 2890 (1983). *Shaw* involved two New York statutes which prohibited employee benefit plans from treating pregnancy differently from other disabilities. Even though the challenged state statutes were enactments of general applicability, not aimed solely at employee benefit plans, this Court had "no difficulty" concluding that each was preempted because of its necessary relation to ERISA-covered plans. 103 S.Ct. at 2899.

Focusing on the operative language of § 514(a), the phrase "relate to," the Court observed that a law normally will relate to an employee benefit plan if it has "a connection with or reference to" such a plan. 103 S.Ct. at 2900. Continuing, the Court noted that the language and structure of the preemption provision made clear that Congress had used the words "relate to" in "their broad sense" (*id.* at 2900), and it supported that analysis with a review of ERISA's legislative history. *Id.* at 2900-01.[4] Reaffirming "*Alessi's* recognition of the exclusive federal role in regulating benefit plans" (*id.* at 2900 n.15), the Court held that an affirmation of federal supremacy was mandated by the "plain language" of § 514(a) and the circumstances surrounding its adoption. *Id.* at 2901.

The Second Circuit, after paying lip service to the holding of *Shaw* that § 514(a) must be given "a broad and liberal construction" (749 F.2d at 138), proceeded to do just the opposite, asserting that the New York statute should not be deemed to relate to welfare benefit plans "unless this conclusion is unavoidable." *Id.* at 138. That assertion is flatly contrary to the holding of *Shaw*, which was based on settled principles of statutory interpretation in the federal preemption context.

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[4] Congress' rejection of a more narrowly-drawn preemption provision coupled with statements by ERISA's sponsors "indicated that the section's pre-emptive scope was as broad as its language." 103 S.Ct. at 2901.

"In deciding whether a federal law pre-empts a state statute, [a court's] task is to ascertain Congress' intent in enacting the federal statute at issue." *Shaw*, 103 S.Ct. at 2899; *accord, Brown v. Hotel & Restaurant Employees & Bartenders Int'l Union Local 54*, 104 S.Ct. 3179, 3185 (1984); *Fidelity Federal Savings & Loan Ass'n v. De La Cuesta*, 458 U.S. 141, 152 (1982). The effort to ascertain what Congress wanted the statute to accomplish "is quite simple if, in the federal enactment, Congress has explicitly mandated the pre-emption of state law." *Brown v. Hotel & Restaurant Employees*, 104 S.Ct. at 3185. In that event, the underlying legislative intent is gleaned from the language and structure of the federal statute, with guidance from the legislative history. *See, e.g., Train v. Colorado Public Interest Research Group, Inc.*, 426 U.S. 1, 9-10 (1976); *United States v. American Trucking Associations, Inc.*, 310 U.S. 534, 542-48 (1940). Applying that analysis to ERISA § 514(a), this Court held that Congress intended benefit plan regulation to be "exclusively a federal concern" (*Alessi*, 451 U.S. at 523), and, to achieve that objective, § 514(a) was written to embody the concept of preemption " 'in its broadest sense' " (*Shaw*, 103 S.Ct. at 2901). The decision below cannot be reconciled with those holdings.

The Second Circuit's legal error was compounded by an unrealistic evaluation of the practical effect of the New York law—an evaluation which obscured the dramatic impact of the statute on the structure and economics of self-insured benefit plans. Thus, the court compared a plan's hospital costs to its utility costs, and then moved to a comparison of state labor laws, rent control laws and bridge and highway tolls. 749 F.2d at 138. Those analogies, however, are fatally flawed, for they overlook a critical fact: *the provision of hospital care and other benefits is the sole purpose for the existence of ERISA welfare benefit plans.* As 29 U.S.C. § 1002(1) states, an employee welfare benefit plan must be established "for the purpose of providing . . . medical, surgical, or hospital care or benefits . . . ." The ancillary costs of running a welfare plan's business (*e.g.*, of keeping the office warm in winter) cannot fairly be compared to the plan's cost of fulfilling its central

function of providing hospital and medical care to its participants at reasonable and competitive rates.[5]

Pursuing its "unavoidability" analysis, the Second Circuit opined that there was "no valid reason why employee benefit plans cannot be subject to nationally uniform supervision despite dissimilarities in their costs of doing business." 749 F.2d at 139. That assertion ignores the main thrust of the challenged statute. The New York law fundamentally altered the existing rate structure for the hospital benefits paid by welfare plans, eliminating in the process a system of negotiated discounts that had made it feasible for the plans to self-insure their benefits.[6] By legislating self-insured ERISA plans into a 15% rate disadvantage compared to Blue Cross, New York may well have made it uneconomical for welfare benefit plans to self-insure in that state.

At the same time, however, self-insurance remains the best way to provide hospital coverage in other states. *See, e.g.*, Petition for Certiorari, at pp. 11-13, comparing the challenged New York law with a Massachusetts statute encouraging self-insurance. In this context, the inevitable effect of the New York law will be to force multi-state plans to maintain, side-by-side, at least two different kinds of hospital benefit programs, or to abandon self-insurance altogether. In *Shaw*, this Court held that federal preemption was intended to avoid precisely those results:

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[5] The opinion in *Lane v. Goren*, 743 F.2d 1337 (9th Cir. 1984), upon which the Second Circuit relied (749 F.2d at 138), does not support the decision below. In *Lane*, an employee of a benefit plan alleged that his discharge had violated state employment discrimination laws. The Ninth Circuit held that those discrimination statutes did not "relate to" the benefit plan because they applied to the plan only "in its capacity as an employer." 743 F.2d at 1340. Here, by contrast, the New York statute strikes at the very heart of the benefit plans' operations—at their role as providers of hospital care and other medical benefits.

[6] *Compare* New York's specific abrogation of discount contracts between hospitals and "self-insured and self-administered groups," N.Y. Pub. Health Law § 2807-a(6)(b), *with* the holding of *Shaw* that a "reference" to benefit plans in a state statute triggers ERISA's preemption provision, 103 S.Ct. at 2900.

> Obligating the employer to satisfy the varied and perhaps conflicting requirements of particular state . . . laws . . . would make administration of a uniform nationwide plan more difficult. The employer might choose to offer a number of plans, each tailored to the laws of particular States; the inefficiency of such a system presumably would be paid for by lowering benefit levels . . . ERISA's comprehensive pre-emption of state law was meant to minimize this sort of interference with the administration of employee benefit plans.

103 S.Ct. at 2904 n.25.

The decision of the Second Circuit, in sum, undermines Congress' intent to "reserve to Federal authority the sole power to regulate the field of employee benefit plans." *Shaw,* 103 S.Ct. at 2901. That decision should be reversed by this Court.

CONCLUSION

The petition of Sebastian Rebaldo for a writ of certiorari should be granted.

Respectfully submitted,

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March 25, 1985

APPENDIX

IN THE

Supreme Court of the United States

OCTOBER TERM, 1984

No. 84-1347

SEBASTIAN REBALDO, as CHAIRPERSON OF THE BOARD OF TRUSTEES OF THE UNITED OPTICAL WORKERS INSURANCE FUND,
Petitioner,

—against—

MARIO CUOMO, GOVERNOR OF THE STATE OF NEW YORK; and DAVID AXELROD, COMMISSIONER OF HEALTH OF THE STATE OF NEW YORK,
Respondents.

On Petition for a Writ of Certiorari to the United States Court of Appeals for the Second Circuit

STIPULATION

Pursuant to Rule 36 of the Revised Rules of this Court, the undersigned agree that the Central States, Southeast and Southwest Areas Health and Welfare and Pension Funds may file a brief as *amicus curiae* in support of the petition for certiorari in this case.

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Dated: February 25, 1985

No. 84-1347

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IN THE

Supreme Court of the United States

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Petitioner,

VS.

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Respondents.

On Petition for a Writ of Certiorari to the United States Court of Appeals for the Second Circuit

BRIEF OF AMICUS CURIAE BLUE CROSS AND BLUE SHIELD OF GREATER NEW YORK

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Petitioner,

VS.

MARIO CUOMO, GOVERNOR OF THE STATE OF NEW YORK; and DAVID AXELROD, COMMISSIONER OF HEALTH OF THE STATE OF NEW YORK,
Respondents.

On Petition for a Writ of Certiorari to the United States Court of Appeals for the Second Circuit

BRIEF OF AMICUS CURIAE BLUE CROSS AND BLUE SHIELD OF GREATER NEW YORK

INTEREST OF THE AMICUS CURIAE

Blue Cross and Blue Shield of Greater New York ("Blue Cross"), with the consent of all parties, submits this *amicus curiae* brief in opposition to the petition for certiorari. The decision below correctly construed ERISA[1] to avoid conflict

[1] The Employee Retirement Income Security Act of 1974, 29 U.S.C. § 1001 *et seq.* (1982) ("ERISA").

with long-standing New York State policy to promote maximum availability of health insurance coverage at affordable rates.

A. The Purpose of NYPHRM

This proceeding seeks to preempt under ERISA one key provision of New York State's Prospective Hospital Reimbursement Method, N.Y. Pub. Health Law §2807-a *et seq.* (McKinney Supp. 1984) ("NYPHRM"), enacted in 1982. NYPHRM is a three year experiment in the comprehensive regulation of all financing for hospital inpatient services, which by its terms ends on December 31, 1985.[2] Adopting NYPHRM, the State's goal was to curb an unacceptable rate of inflation in the cost of hospital care, and at the same time to ameliorate operating deficits plaguing certain not-for-profit hospitals as well as distribute more equitably the burden of funding hospital services.

NYPHRM, for the first time, empowers the State to control all aspects of hospital care financing by regulating all sources of hospital revenue—particularly, the prices at which all persons may purchase hospital services. Before NYPHRM, the State controlled reimbursement to hospitals by the State Medicaid Program and by not-for-profit insurers such as Blue Cross. Also, pre-NYPHRM, the State regulated the charges that hospitals levied upon others. However, the State had no power over the largest single purchaser of hospital services, the federal Medicare Program. The upshot was that while the State had

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[2] Since NYPHRM runs out at year's end, now under consideration is whether to extend NYPHRM, as is or in some altered form, as well as alternative modes for financing hospital services in New York. On such issues, all interested parties have had their say, including State officials, legislators, commercial carriers, the State's Blue Cross plans, representatives of self-insured funds and other persons. If NYPHRM is allowed to expire and the financing of hospital inpatient services is determined pursuant to a new statute or returned to the methodology that NYPHRM replaced, this case will be moot. Likewise, if NYPHRM is to be extended, self-insured funds are urging the very change in NYPHRM that petitioner seeks to bring about through ERISA preemption. Such an amendment would also render the case moot.

long since decreed that Medicaid and Blue Cross reimburse hospitals at prospectively determined rates that accounted only for efficient performance of services, Medicare operated under no such discipline. Since the State had "no role in setting Medicare rates or handling Medicare payments . . . Medicare continued until 1982 to calculate hospital entitlements on the basis of costs computed at the end of each fiscal year." (App. 4.)[3] Because NYPHRM would not work unless Medicare reimbursement was brought under effective State regulation, the Legislature specified that NYPHRM could not take effect until the federal government agreed to adopt NYPHRM's methodology for Medicare reimbursement. 1982 N.Y. Laws 536 § 10(a).

New York thus applied for a Medicare "waiver," *i.e.*, authorization from the federal government to adopt NYPHRM as an experiment in Medicare reimbursement that was other than cost-based.[4] This waiver the federal government granted in December of 1982, and the State promptly proceeded to implement NYPHRM.

B. The Operation of NYPHRM

NYPHRM requires that the State "establish for each hospital an 'inpatient revenue cap', i.e., the maximum amount of inpatient revenue the hospital will be authorized to receive for services during a twelve-month period . . . ." (App. 7.) Each "general hospital is [then] required to establish a charge schedule sufficient to generate the inpatient revenue authorized by the revenue cap" (*id.*), taking into account that the Legislature had determined that certain payors were to receive a "differential" from the hospitals' gross charges. *See* § 2807-a(6)(b). At the same time, the Legislature concluded

[3] References are to the Appendix to the Petition.

[4] From the outset of Medicare, Congress had empowered the Secretary of Health, Education and Welfare to engage in "experiments and demonstration projects" to determine, *inter alia*, "whether the rates of payment or reimbursement for health care services, approved by a State . . . would have the effect of reducing the costs of such programs [Medicare] without adversely affecting the quality of such services." 42 U.S.C. § 1395b-1(a)(1)(C) (1982).

that all other payors, government-sponsored as well as private, were to pay the hospitals' established charges.

Thus, NYPHRM prescribes two levels of payment for hospital inpatient services. The first is based on each hospital's prospectively determined and efficiently incurred costs and applies to the federal Medicare program, the State's Medicaid program, corporations under Article 43 of the Insurance Law, which includes the State's Blue Cross Plans, and health maintenance organizations throughout New York. All other payors, such as commercial carriers, the State's Workers Compensation program, its no-fault insurance program, uninsured persons, and self-insurers such as the petitioner, pay the hospital's charges, which are set by statute at no more than 12-15% above such "costs." NYPHRM does not distinguish among charge-payors except to permit hospitals to continue any "negotiated payment rate determination systems [with] self-insured and self-administered groups" that were already in effect on May 1, 1982.

C. The Role Of Blue Cross In New York's Health Care Delivery System

Blue Cross is a not-for-profit health services corporation organized and operating for almost one-half century now pursuant to Article 43 (formerly Article IX-C) of the New York State Insurance Law. Blue Cross operates in a 17-county area that includes New York City and its environs. It provides hospital and health related benefits to some 9 million persons. An additional 4 million persons are covered by other Blue Cross plans that operate, also pursuant to Article 43, throughout the State.

New York State's Superintendent of Insurance and Commissioner of Health closely regulate all aspects of Blue Cross's operations. Thus, Blue Cross can offer no contract to subscribers without the prior approval of the Superintendent. N.Y. Ins. Law § 4308 (McKinney 1984). Similarly, Blue Cross rates or "premiums" to its subscribers must also be approved by the Superintendent. (*Id.*) Blue Cross can reimburse hospitals and

other institutional providers of care to subscribers only in precise accord with the reimbursement methodology prescribed by the Commissioner of Health under NYPHRM.

Since its founding in the 1930's, Blue Cross has been regulated by the State in such a manner as to further various community ends the State has deemed worthy. Included among these ends are the following:

> *First*, via its "open enrollment" periods, during which any person regardless of prior illness, physical condition, age or sex can obtain health insurance, and its Medicare supplementary coverage, Blue Cross—unlike commercial carriers—affords coverage at a uniform community-wide rate otherwise unavailable for high-risk individuals. Community-rated and Medicare supplementary coverage resulted in an operating loss for Blue Cross of $116,000,000 for the three year period ended December 31, 1982;
>
> *Second*, to provide hospitals needed operating funds, Blue Cross, but no charge-payor under NYPHRM, makes various interim payments to hospitals and otherwise provides their working capital prior to formal submission of claims. During 1983 the average outstanding balance in the advanced financing program was $180,400,000 which reduced Blue Cross's investment income by almost $20,000,000;
>
> *Third*, Blue Cross provides comprehensive coverage which, in turn, limits the amount of bad debts incurred by hospitals, bad debts which ran roughly $260,000,000 in 1982, the year before NYPHRM went into effect.

Recognizing the cost of such public functions as well as the fact that NYPHRM both decreased Blue Cross's pre-NYPHRM "differential" and otherwise increased Blue Cross's annual costs another $100,000,000 by requiring contribution to a hospital bad debt and charity pool, the Legislature deter-

mined that Blue Cross (along with Medicare and Medicaid) should purchase hospital services on a basis different from other payors.[5] Invalidation of § 2807-a(6)(b), as petitioner here seeks, would undermine this difference in treatment and leave one category of payors, self-insured benefit plans, free from any State regulation over the price at which they may negotiate for hospital services. Such consequence would disparage Blue Cross's ability to perform those community functions with which it has been charged.

Blue Cross, to repeat, is required to insure, on a "community-rated" basis, persons and groups that are, on the whole, older, poorer and less healthy than "experience-rated" groups and therefore constitute unacceptably high risks for other insurers. To insure all persons at a uniform and affordable "community" rate, Blue Cross relies on a subsidy which it collects from its "experience-rated" groups. Without a hospital payment differential, premiums to such groups could not be set at a level that would provide the necessary subsidy, without losing them to competitors who accept no such public responsibility. Typically, "experience-rated" groups are comprised of members who are employed, on the whole younger, and generally healthier than those who pay the community rate. Covering such "experience-rated" groups, Blue Cross includes a 1% subsidy for community rates in its retention formula used in calculating rates. Beyond that, all investment income earned on premiums paid by "experience-rated" groups goes to subsidize the community rate.

In short, for Blue Cross to continue to offer adequate protection to those whose needs are the greatest, it must depend upon, and also be attractive to, those groups whose needs are less. However, it is those "experience-rated" groups with lesser needs that, afforded a unique freedom from regulation and the right to negotiate hospital rates, would be most likely to move

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[5] As the district court concluded, "defendants and *amicus* have provided the Court with considerable justification for the payment rate differential established between ERISA plans and corporations such as Blue Cross." (App. 27.)

away from Blue Cross, thereby eroding the very subscriber base on which State policy has long banked in utilizing Blue Cross as its instrument for affordable community rates.

STATEMENT OF THE CASE

Petitioner is Chairperson of a self-insured and self-administered employee welfare benefit plan (the "Fund") regulated by ERISA. The Fund had no contracts in place with hospitals at the statutory cutoff date of May 1, 1982. As of the date it became a self-insurer on January 1, 1983, the Fund apparently entered into contracts with hospitals for inpatient services at rates below those prescribed in § 2807-a(6)(b). In December, 1983, almost one and one-half years after NYPHRM was enacted, this suit was commenced to preserve those contracts entered into after NYPHRM's deadline.

The district court for the Southern District of New York granted summary judgment for petitioner and declared § 2807-a(6)(b) to be preempted by ERISA § 514(a) "to the extent it prohibits a hospital from establishing inpatient charges for self-insured employee benefit plans covered by ERISA which are other than those authorized by Public Health Law § 2807-a(6)." (App. 45.)

Vacating the decision of the district court, the United States Court of Appeals for the Second Circuit held, in *Rebaldo v. Cuomo,* 749 F.2d 133 (2d Cir. 1984), that § 2807-a(6)(b) does not purport to regulate the structure, administration or benefits afforded by ERISA plans. Therefore that statute was deemed not to "relate to" ERISA plans and not preempted under ERISA § 514(a).

SUMMARY OF ARGUMENT

Petitioner has failed to show that the decision below conflicts with the decision of any other court of appeals or with applicable decisions of this Court. As a result, the petition for certiorari should be denied.

ARGUMENT

THE DECISION BELOW IS CONSISTENT WITH DECISIONS OF THIS COURT AND DOES NOT CONFLICT WITH DECISIONS OF OTHER CIRCUITS

The beginning point below was that, reading ERISA §§ 514(a) and 514(c)(2) together, "a state law must 'purport[ ] to regulate . . . the terms and conditions of employee benefit plans' to fall within the preemption provision" (App. 9). The court recognized the "broad and liberal construction" given the term "relate to" by the Supreme Court in *Shaw v. Delta Air Lines, Inc.*, 103 S. Ct. 2890 (1983) (App. 10) and that "ERISA preempts state laws that require or forbid the provision of a certain kind of benefit." (App. 11.) At the same time, the court went on to emphasize that:

> ERISA does not invalidate those State statutes whose effect on pension plans is simply tangential in nature. . . . This conclusion follows as a matter of common sense from the fact that ERISA plan members and managers are bound to engage in myriad transactions that Congress never considered when it drafted § 514. A preemption provision designed to prevent state interference with federal control of ERISA plans does not require the creation of a fully insulated legal world that excludes these plans from regulation of any purely local transaction. (App. 10.)

This conclusion applies with particular force where, as here, the "containment of hospital costs is an exercise of a State's police powers, which should not be superseded by federal regulations unless that was the clear intent of Congress." (*Id.*)

Against that background, the court held that "New York's decision to regulate the amounts hospitals can charge" was among those "state actions [that] may affect employee benefit plans in too tenuous, remote, or peripheral a manner to warrant a finding that the law 'relates to' the plan." (App. 11.) Rejected because it "proves altogether too much" was the contention

that NYPHRM should be preempted because it increased the Fund's cost of doing business:

> The purchase of hospital service is like the purchase of public utility service, or of any other service or commodity whose price is controlled by the State. Insofar as the regulation of hospital rates affects a plan's cost of doing business, it also may be analogized to State labor laws that govern working conditions and labor costs, to rent control laws that determine what employee benefit plans pay or receive for rental property, and even to such minor costs as the Thruway, bridge and tunnel tolls that are charged to plans' officers or employees. In short, if ERISA is held to invalidate every State action that may increase the cost of operating employee benefit plans, those plans will be permitted a charmed existence that never was contemplated by Congress. Where, as here, a State statute of general application does not affect the structure, the administration, or the type of benefits provided by an ERISA plan, the mere fact that the statute has some economic impact on the plan does not require that the statute be invalidated. (App. 12.)

Nor was whatever "indirect economic impact as may result from State control over hospital rates" deemed to "run counter to ERISA's aim of national uniformity in plan regulation." (App. 12-13.) For even without NYPHRM, "every hospital will be able to set its own rates for ERISA plans, and [petitioner] does not contend that these rates are, or will be, uniform, even as between hospitals in the same locality. Lack of uniformity is not a valid argument for preemption of New York's statute." (App. 13.)

A. The Decision Below Squares With Prior Decisions By This Court

In *Shaw v. Delta Air Lines, Inc.*, 103 S. Ct. 2890 (1983), for example, the Court held that subsections of two New York statutes relating to discrimination on the basis of pregnancy—the Human Rights Law and the Disability Benefits

Law—"relate[d] to" ERISA plans, the former because it required a specific structure in such plans and the latter because it required that the plans pay specific benefits. *Id.* at 2900. As noted by the court below, by way of contrast, NYPHRM regulates neither the structure of nor benefits to be provided by ERISA plans. In addition, while the purpose of the laws in *Shaw* was to regulate employment practices, which includes the provision of employee benefits, the purpose of NYPHRM is solely to regulate hospital costs and is in no way concerned with the structure, administration or benefits package of ERISA plans.

Similarly, unlike *Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504 (1981), no conflict exists between NYPHRM and federal law. In *Alessi,* the New Jersey Workers' Compensation Act, which prohibited the integration of pension benefits with workers' compensation awards, was deemed to be preempted because Congress had deliberately permitted integration. Hence, preemption was based on the narrow ground that there existed a "direct clash between the state statute and the federal policy to keep calculation of pension benefits a subject of either labor-management negotiations or federal legislation." *Id.* at 526 n.22.[6] In contrast, no federal policy can be derived from ERISA or any other federal law, with respect to the price payable by particular persons—ERISA plans or anyone else —for hospital inpatient services.

Also misplaced is petitioner's reliance on *Alessi* for the proposition that NYPHRM is preempted because through its regulation of hospital costs it "indirectly" regulates ERISA plans. (Petition, at 15-16.) As the Third Circuit found in *Alessi,* the "*only* purpose and effect of the [New Jersey] statute is to set forth an additional statutory requirement for pension plans." *Buczynski v. General Motors Corp.*, 616 F.2d 1238, 1250 (3d Cir. 1980), *aff'd sub nom. Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504 (1981) (emphasis in original). Thus, the

[6] The Supreme Court in *Shaw* recognized that the *Alessi* decision rested narrowly on "the state law's frustration of [particular] Congressional intent." *Shaw,* 103 S. Ct. at 2900 n.15.

statute was "indirect" only in that the pension regulation was embodied in a workers' compensation law.

Here, New York State makes no attempt to "avoid[ ] through form the substance of the preemption provision." *Alessi,* 451 U.S. at 525. NYPHRM in form and in fact is a hospital cost containment statute. Nowhere mentioned is ERISA. It does refer to "negotiated payment rate determination systems between self-insured and self-administered groups"—but only to preserve those already in effect when NYPHRM was enacted. The fact is that the great bulk of ERISA plans are not "self-insured and self-administered groups," and many of the most significant "employee benefit plans" are exempt from ERISA. *See* 29 U.S.C. §§ 1002(1), 1002(32), 1003(b)(1).

B. The Decision Below Accords with Applicable Decisions from Other Circuits.

Thus, *Standard Oil Co. v. Agsalud,* 633 F.2d 760 (9th Cir. 1980), *aff'd mem.,* 454 U.S. 801 (1981), held that ERISA preempted Hawaii's Comprehensive Prepaid Health Care Act which, unlike NYPHRM, "directly and expressly regulates employers and the type of benefits they provide employees." 633 F.2d at 766.[7] The decision below acknowledged that "ERISA preempts state laws that require or forbid the provision of a certain kind of benefit" (App. 11), but correctly concluded that NYPHRM was not such a law.

There is likewise no conflict with *Hewlett Packard Co. v Barnes,* 571 F.2d 502 (9th Cir.), *cert. denied,* 439 U.S. 831 (1978). The California Knox-Keene Health Care Service Plan Act there preempted indisputably regulated ERISA plans. The California Act regulated "health care service plans" which were any plans providing health care services or insurance (including self-insurance) in return for a prepaid charge. As noted by the

[7] In fact, the State itself in *Agsalud* argued that the Hawaii Act did not "relate to" an employee benefit plan because it "pertain[ed] principally to benefits rather than administration." *Id.* at 765.

district court, the Act directly regulated "such areas as funding, disclosure, sales practices and quality of services." *Hewlett-Packard Co. v. Barnes,* 425 F. Supp. 1294, 1297 (N.D. Ca. 1977), *aff'd,* 571 F.2d 502 (9th Cir.), *cert. denied,* 439 U.S. 831 (1978).[8]

C. Without Record Basis Are Petitioner's Claims Of Adverse Impact

Finally, the petitioner, as well as the *amici,* fall back on the prediction of dire consequences for self-insurance if the decision below is allowed to stand. Thus, petitioner asserts that § 2807-a(6)(b) makes self-insurance unprofitable, that all previously self-insured funds will be forced to return to Blue Cross and will then be forced to accept state-mandated benefits they might otherwise not want to provide for their members. To this point the short answer offered below suffices:

> Where, as here, a State statute of general application does not affect the structure, the administration, or the type of benefits provided by an ERISA plan, the mere fact that the statute has some economic impact on the plan does not require that the statute be invalidated. (App. 12.)

---

[8] Similarly wide of the mark is the suggestion that the "issues presented are related closely to those before the Court in *Metropolitan Life Insurance Company v. Massachusetts,* No. 84-325, *argument scheduled.*" (Petition at 1.) While both concern ERISA preemption, at this juncture the issues presented to this Court are otherwise dissimilar.

In *Metropolitan,* the question is whether a Massachusetts statute that requires insurance companies to provide specified medical benefits in all their contracts, presumably including those sold to ERISA plans, is saved from preemption by ERISA § 514(b), the insurance savings clause. In the present case, the Second Circuit determined that NYPHRM was not preempted by ERISA because the state statute did not "relate to" ERISA plans. Hence, even if this Court determines that the Massachusetts statute in *Metropolitan* is preempted, based on an interpretation of the scope of the insurance savings clause urged by appellant herein, such a decision would have no effect on whether § 2807-a(6)(b), which regulates the price hospitals can charge for inpatient services, "relates to" ERISA plans.

CONCLUSION

The petition for a writ of certiorari should be denied.

Respectfully submitted,

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APPENDIX

SUPREME COURT OF THE UNITED STATES

OCTOBER TERM, 1984

SEBASTIAN REBALDO, as Chairperson of the Board of Trustees of the UNITED OPTICAL WORKERS INSURANCE FUND,

Petitioner,

—against—

MARIO CUOMO, GOVERNOR OF THE STATE OF NEW YORK; and DAVID AXELROD, COMMISSIONER OF HEALTH OF THE STATE OF NEW YORK,

Respondents.

IT IS HEREBY AGREED by and between the parties herein, through their counsel, that consent is given, pursuant to Rule 36 of the Revised Rules of this Court, for Blue Cross and Blue Shield of Greater New York to file a brief in this proceeding before the Supreme Court of the United States as *amicus curiae.*

Dated: New York, New York
March 6, 1985

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No. 84-1347

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IN THE

Supreme Court of the United States

October Term, 1984

SEBASTIAN REBALDO, as Chairperson of the Board of the Trustees of the UNITED OPTICAL WORKERS FUND,

Petitioner,

against

MARIO CUOMO, GOVERNOR OF THE STATE OF NEW YORK; and DAVID AXELROD, COMMISSIONER OF HEALTH OF THE STATE OF NEW YORK,

Respondents.

On Petition for a writ of Certiorari to the United States Court of Appeals for the Second Circuit

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38 pp

Question Presented

Is an experimental New York statute that regulates the price of all hospital inpatient charges preempted by § 514(a) of the Employee Retirement Income Security Act of 1974, 29 U.S.C. § 1144(a), when the charges are paid by ERISA-covered, self-insured employee welfare plans?

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Statement of the Case

A. New York's Prospective Hospital Reimbursement Methodology

Public Health Law ("PHL") § 2807-a(6) (McKinney's Consolidated Laws of New York 1984-85 Supp.), the state statute involved, requires each of New York's three hundred general hospitals to establish equal charges for its inpatient services when the level of payment for the services is not determined by state-established or approved inpatient rates. The requirement is part of a three-year experimental program, known as New York's Prospective Hospital Reimbursement Methodology or NYPHRM, that will end on December 31, 1985 unless renewed by the Legislature. Opinion below at 7a; Governor's Memorandum on Approving NYPHRM ("Governor's Memorandum"), 1982 McKinney's Session Laws of New York 2608. NYPHRM is New York's most recent response to one of the most intractable problems of public health and welfare—the delivery of quality inpatient services, by financially sound hospitals, at reasonable, equitably apportioned cost. Opinion below at 3a, 4a, 7a, 15a-16a; district court opinion at 20a, 38a; Governor's Memorandum, *id.* at 2608-2609.* The program has three essential components: state-established inpatient revenue caps, *i.e.* income ceilings (PHL § 2807-a[1]-[4]; state-established or approved inpatient rates (§§ 2803[2], 2807[2], [3], 2807-a [1]) and equal charges (§ 2807-a[6] [statute involved]);

* NYPHRM's enactment was preceded by almost four years of study, negotiations, public hearings and comment. District court opinion at 20a; Governor's Memorandum, *id.* at 2608. The state Council on Health Care Financing conducted the major pre-NYPHRM study. It's final report, *Recommendations for Financing Inpatient Care* (State of New York 1980) ("Recommendations"), proposed a new system for financing inpatient care which, in accord with the Council's legislature mandate (L. 1978, L. 520, §§ 2, 4), was uniform, encouraged economy and equitably distributed cost. The proposed system, with modest changes, was adopted as NYPHRM. Excerpts from the Council's Recommendations are reproduced at 71-172 of the joint appendix in the United States Court of Appeals for the Second Circuit. Respondents' attorneys have transmitted copies of the Second Circuit appendix to the Clerk. *See* Supreme Court Rule 13(1),(3).

and state-mandated contributions to offset losses from bad debt and charity care. § 2807-a(1), (9).*

NYPHRM's comprehensive regulation of the field and inter-dependent components distinguish the program from New York's past responses to the problem of financing $8 billion in inpatient services its hospitals provide annually. Opinion below at 3a; A. ¶30.** NYPHRM's first component, an inpatient revenue cap established by the state Commission of Health for each general hospital, is the amount of money the hospital needs to provide inpatient services efficiently for a period of time, usually one year, and the amount of income it will be allowed to receive for the services. PHL § 2807-a(1); opinion below at 7a. Revenue caps, which did not exist in New York before NYPHRM, address fiscal stability and cost containment objectives since they permit each hospital to receive the money it needs for its inpatient services and no more. Opinion below at 7a; Governor's Memorandum, *id.* at 2608-2609.

NYPHRM's second component, state-established or approved inpatient rates (PHL §§ 2803[2], 2807[2],[3], 2807-a[1]) and equal charges (§ 2807-a[6] [statute involved]), distribute the cost of each hospital's inpatient services, as determined by its revenue cap, among the consumers of the services or their third party payors. The program has two categories of payors, cost payors and

* NYPHRM includes Medicare rates within state-established rates. The state's acquisition of jurisdiction over Medicare rates was a precondition to NYPHRM's operational status (L. 1982, c. 536, § 10[a]) and followed a waiver of federal authority granted by the United States Department of Health and Human Services ("HHS"). The HHS waiver is for a three-year period commencing on January 1, 1983. Second Circuit joint appendix ("A.") at 220; opinion below at 7a. It relies on § 402(a), (b) of the Social Security Amendments of 1967, 42 U.S.C. § 1395b-1(a)(1)(C), (b); A. 220. The legislation authorizes the Secretary to waive federal Medicare reimbursement standards to determine, in the context of an experiment or demonstration project, if state reimbursement standards, when applied to Medicare, reduce cost without adversely affecting patient care. See opinion below at 5a-7a, 14a-15a.

** References preceded by "A." are to pages of the Second Circuit joint appendix.

charge payors. Medicare, Medicaid, non-profit health insurance corporations ("non-profit health insurers" or "non-profit insurers")* and health maintenance organizations ("HMO's")** are cost payors. Cost payors meet approximately eighty-five percent, $6.8 billion, of the annual cost of inpatient services in New York. District court opinion at 21a; A. 386 ¶6.† They pay state-established or approved per diem rates set prospectively for each hospital.‡

* Non-profit health insurers are licensed under article 43, formerly article 9-C, of the New York Insurance Law (McKinney's Consolidated Laws of New York, 1984 Special Pamphlet.) The petition (at 4) and the NYPHRM legislation, which antedates the recodification of the Insurance Law, use the former article 9-C designation. *See e.g.* PHL § 2807-a(1), (4), (6), (11), (12). The petition (at 4) also identifies all non-profit health insurers in New York as "Blue Cross." See also Brief of *Amicus Curiae* Central States, Southeast and Southwest Areas Health and Welfare Fund ("Central States *amicus curiae* brief") at 4. In fact, there are twelve non-profit health insurers in the state that provide coverage for inpatient services. Five of the insurers, including the *amicus curiae*, Blue Cross and Blue Shield of Greater New York, are fiscally independent Blue Cross plans. They provide most of the coverage, either directly or indirectly. Three of the insurers, Capital Area Community Health Plan (Albany) and Genesee Valley Group Health Association, both also health maintenance organizations ("HMO's"), and Health Insurance Plan of Greater New York, provide coverage through contracts with Blue Cross plans. Four of the insurers, including Health Care Plan, Inc. (Buffalo), also an HMO, provide coverage themselves, *i.e.* without any relationship to a Blue Cross plan.

** HMO's are enrollee plans, certified under Public Health Law article 44, that provide comprehensive health services, directly or indirectly, for advance or periodic payments. PHL §§ 4401, 4405, 4410(1). There are sixteen HMO's in New York.

† All dollar amounts and percentages are for the 1983 calendar year, the last year for which data is available in the district court record. References preceded by "A." are to pages of the Second Circuit joint appendix.

‡ Prospective per diem rates for cost payors, whether established by the state Department of Health in the first instance, *i.e.* Medicaid and Medicare, certified by the Commissioner of that Department, *i.e.* HMO's and non-profit health insurers, or by other state officials, *i.e.* the state Superintendent of Insurance for non-profit health insurers, must conform with the state's Medicaid/Medicare rate methodology set forth in 10 New York Codes, Rules and Regulations ("NYCRR") subpart 86-1. PHL §§ 2803 (2), 2807-a(1) (¶4), (12); 10 NYCRR § 86-1.2(a).

Commercial health insurers, no-fault insurance, workers compensation, self-insured health plans, like petitioner's United Optical Workers Insurance Fund, and self-pay patients, *i.e.* patients without third party payors, are charge payors. Charge payors meet the remaining fifteen percent, of the annual cost of inpatient services in New York. A. 386 ¶6.* Since NYPHRM, they pay inpatient charges established by each hospital under PHL § 2807-a(6) (statute involved). Under § 2807-a(6), each hospital must bill all its charge payors at equal charges, *i.e.* at the same per service price, and must establish the charges at certain levels above its recent non-profit health insurer rate. *Ibid.*** There are two minor exceptions. Hospitals may

* Commercial insurers meet approximately eleven percent of the cost of inpatient services in New York, self-insured health plans and self-pay patients, together, approximately, four percent. A. 386 ¶6. The record does not identify the number of self-insured health plans operating in New York or their status under the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. §§ 1001-1461. Petitioner did not inform the lower courts of the number of self-insured plans which, like its own plan, are ERISA-covered, and respondents' efforts to obtain this information from the United States Department of Labor were unavailing. There are twenty-five state-licensed (*i.e.* under Insurance Law article 44) self-insured plans in New York that provide coverage for inpatient services. None is an ERISA-covered plan since the United States Department of Labor has exclusive jurisdiction over those plans.

** The difference between a hospital's cost, the basis for the rates paid by Medicaid, Medicare and article 43 non-profit health insurers, and a hospital's charges varies between twelve and fifteen percent under PHL § 2807-a(6)(b). Special obligations imposed on non-profit insurers support the differential for them. Under directives of the state Superintendent of Insurance, the corporations must offer policies to the community at large at modest premiums. A. 204-12. These community-rated policies usually insure high risks who would be denied commercial policies. A. 208-209 ¶30. The non-profit insurers subsidize the community-rated policies with premiums from their more selective, experience-rated group policies. A. 206 ¶26, 210 ¶33. The differential the non-profit insurers receive permits them to offer their experienced-rated group policies at premiums competitive with commercial insurers and, in turn, to subsidize the community-rated policies they are obligated to provide. A. 211-12 ¶35. See also Brief of *Amicus Curiae* Blue Cross and Blue Shield of Greater New York ("Blue Cross *amicus curiae* brief") at 4-7. *Contrast* petition at 5 n.3, attributing the state's interest in keeping Blue Cross plans (and, presumably, other article 43 insurers) competitive to a lobbying effort by "Blue Cross," a claim wholly without foundation in the record.

establish charges for HMO's through negotiated agreements approved by the state Commissioner of Health. § 2807-a(1) (¶15);* and they may continue negotiated agreements with self-insured health plans that were in effect on May 1, 1982, a date before NYPHRM was enacted. § 2807-(a)(b)(ii).**

State-established or approved inpatient rates and the complementary equal charges requirement, which did not exist in New York before NYPHRM, implement the revenue cap and address fiscal stability and cost-containment objectives. Hospitals are assured the income they need to fund their inpatient services, *i.e.* each hospital must establish its equal charges at a level which, when added to its rates, is "sufficient to generate the inpatient revenue authorized by . . . [its] revenue cap." PHL § 2807-a(6)(a).

* The state Commissioner of Health can approve negotiated hospital/HMO charges agreements only if they encourage patient self-management, thereby reducing the length of hospital stays, or include special benefits, *e.g.* discounts. PHL § 2807-a(1)(¶5).

** The PHL § 2807-a(6)(b)(ii) exception for pre-NYHRM hospital/self-insured health plan agreements adopts a recommendation of the Council of Health Care Financing (A. 141-42) which was informed that agreements of this kind were outstanding. A. 141. The petition (at 5 n.3) observes that state officials did not know how many agreements were subject to the § 2807-a(6)(b)(ii) exception albeit, given the basis for the Council's recommendation (A. 141), they knew there would be some. The observation is correct because the § 2807-a(6)(b)(ii) exception includes agreements between hospitals and ERISA-covered plans about which state authorities had, and have, no information. A. 162 ¶1. See p. 4 n.*.

The petition's further observation (at 5 n.3, 11), that NYPHRM "abrogated" outstanding negotiated charges agreements between hospitals and self-insured health plans, is false. PHL § 2807-a(6)(¶1) prohibits hospital/plan charges agreements after the January 1, 1984, the effective date of the equal charges requirement. The § 2807-a(6)(b)(ii) exception continues all pre-NYPHRM hospital/plan charges agreements in effect on May 1, 1982. Thus agreements made between July 20, 1982, the date NYPHRM was enacted (L. 1982, cc. 536-38), and the January 1, 1984 date for the equal charges requirement, including all the agreements entered into by the United Optical Workers Insurance Fund (A. 20 ¶3[a]), were made with the knowledge that negotiated charges were prohibited on and after January 1, 1984. Accordingly, none of these agreements could extend beyond January 1, 1984, and any agreement that purported to do so was prohibited by § 2807-a(6), not abrogated by it.

Overall inpatient services cost is contained because rates and charges are state-regulated, and no hospital's income can exceed its need, as determined by its revenue cap. § 2807-a(a) and p. 2. The rates and equal charges address a third objective as well, equitably apportioning the cost each hospital's inpatient services among all of its payors. Opinion below at 15a; L. 1978, c. 530, § 4 (new system for financing health care must assure equitable payment from all sources); *Recommendations for Financing Inpatient Care,* Council on Health Care Financing (State of New York 1980) ("Recommendations") at A. 131-35.

State-established or approved rates and the complementary equal charges requirement also resolve practical problems that diminished the effectiveness of New York's past responses to the problem of financing inpatient services. For example, NYPHRM required state Department of Health jurisdiction over Medicare rates (L. 1982, c. 536, § 10 [a]) to eliminate inconsistencies between state and federal cost containment strategies.* NYPHRM required specific differentials between cost and charge payors (PHL § 2807-a[6][b][i][¶¶1, 2]) and equal charges for all charge payors (§ 2807-a[6]) to eliminate cost-shifting among payors. District court opinion at 21a; A. 61 ¶12. In 1982, before the program's specific differentials became effective, charge payors paid one hundred and forty percent more than the average non-profit health insurer rate in some areas of the state and one hundred and twenty-five percent more than

* The state, before NYPHRM, could only establish or approve prospective rates for Medicaid, state government programs, non-profit health insurers and HMO's. PHL §§ 2803(2), 2807(2), (3). These prospective state rates limited each hospital's reimbursement from these sources to a predetermined amount and, to the extent they were applicable, effectively contained the cost of inpatient services. Opinion below at 3a, 4a; A. 57-58 ¶6, 59-60 ¶9. HHS, in contrast, could only establish retrospective rates for Medicare. Opinion below at 4a-5a; A. 58 ¶7. The rates did not limit Medicare reimbursement to a predetermined amount and were less effective in containing cost. *Ibid.* The state Department of Health's acquisition of jurisdiction over Medicare rates under NYPHRM allowed it to unify all rates under the state's more effective prospective methodology. Opinion below at 3a, 4a-7a.

average the non-profit insurer rate statewide. A. 62 ¶15. Before the program's equal charges requirement became effective, charge payors could, and did, combine to negotiate inpatient charges as a block. *Ibid.* The favorable terms they obtained for themselves were at the expense of other charge payors. *Ibid.**

NYPHRM's third component, mandated contributions from each hospital to reimburse losses from bad debt and charity care (PHL § 2807-a[1][¶4], [9]), completes the program. Again, the revenue cap is implemented and fiscal stability addressed by assuring each hospital partial reimbursement in the event of a payor default. Again, like state-established Medicare rates and the equal charges requirement, the component did not exist in New York before NYPHRM and resolves a practical problem. Before it was adopted, approximately five percent of inpatient services days in the state went unpaid because of payor defaults. A. 61 ¶13. The problem was most acute for inner-city hospitals that suffered a disproportionate share of defaults. *Ibid.*

The measure of NYPHRM as an experiment and the financial viability of the hospitals whose inpatient income, rates and charges are controlled by the program depend

* The petition (at 4-5, 9, 13, 20-21) creates the impression that NYPHRM economically favors large cost payors, like the Blue Cross plans, at the expense of small charge payors, like self-insured health plans. See also Central States *amicus curiae* brief at 2, 3, and Brief *Amicus Curiae* of Local 338 Health and Welfare Fund and Local 814 Welfare Fund ("Local 338 *amicus curiae* brief") at 3, 4-5, 7, 9, 10, 12-13. The program was not intended to, and does not in fact, do so. NYPHRM increased the per diem rates paid by Blue Cross plans seven to eight percent (A. 305, 306) and reduced their differentials as well as those of other non-profit health insurers. See p. 4 n.**. The program also increased Medicaid rates by some $50 to $70 million over its three-year life. Governor's Memorandum, *id.* at 2609. NYPHRM's equal charges requirement reduced the charges of charge payors, including self-insured health plans, that had been paying one hundred twenty-five percent to one hundred and forty percent more than the average non-profit health insurer rate. See text above. To the extent the equal charges requirement prohibited hospitals from granting new discounts to self-insured health plans, it eliminated an economic advantage those plans had obtained at increased cost to other charge payors.

on the maintenance of comprehensive regulation. As the Council on Health Care Financing said when it proposed the program: "It cannot be stressed too strongly that the reimbursement system . . . is an overall coordinated system with each component intra-related to the other components . . . . The . . . system cannot be applied on a selective basis . . . ." Recommendations, A. 132-33. The petition's opposing contention (at 5), that the prospective elimination of the equal charges requirement (PHL § 2807-a [6]) for self-insured health plans would have no discernable impact, ignores the inter-relationship among program components considered necessary by the Council and established by the Legislature. It also ignores the risk to the fiscal stability of hospitals that would follow the deregulation of charges to self-insured plans.

If, as the petition proposes (at 5), hospitals are foreclosed from billing self-insured health plans equal charges, and required, instead, to negotiate discount agreements with the plans, the hospitals' inpatient income will fall below the amount they need to provide inpatient services as soon as the first agreement takes effect. Inpatient income falls below need because the proposed discount charges will not meet the hospitals' revenue cap requirements, *i.e.* rates plus equal charges (PHL § 2807-a[6][b] and pp. 2-3), and, given continuing NYPHRM regulation of rates and equal charges for all payors except self-insured health plans, hospitals will not be able to make-up losses from plan discounts by shifting them to other payors. A. 390 ¶11 and pp. 6-7.

Moreover, inpatient income lost through negotiated discounts for self-insured health plans will increase with time. The proposed elimination of the equal charges requirement for the plans provides an incentive to other payors, *i.e.* those who pay equal charges or health insurance premiums, to establish themselves as self-insured plans in order to obtain the advantages of the deregulated discount charges. A. 391 ¶14. As the number of inpatients represented by self-insured plans increases, through the payor conversions to plan status, the volume of inpatient services provided at

discount charges increases, and the bargaining power of the plans to demand deeper discounts increases. *Ibid.* As a result, the hospitals' income falls continuously and increasingly below their need. A. 391 ¶¶13, 14.* Indeed, were the petition's proposal adopted, it would eventually restore and exacerbate pre-NYPHRM conditions. Hospitals would become fiscally unsound, if not insolvent, because their inpatient income would be insufficient. See pp. 2-3, 8-9. Bargaining power, not the cost of inpatient services, would determine charges, with large commercial health insurers and self-insured health plans receiving the economic advantage over small plans and self-pay patients. See pp. 7, 8-9. Differentials between self-insured health plans and

* The petition claims (at 5 n.3), erroneously, that the elimination of the equal charges requirement for self-insured health plans would affect only one percent of the inpatient income of the hospitals in New York and that the "danger[s]" that follow deregulation, noted just above, are attributable to a state animus against self-insurers or self-insured health plans.

The petition's one percent inpatient income figure (at 5 n.3) was offered by an accountant for the United Optical Workers Insurance Fund. Affidavit of Charles Pendola, sworn to May 1, 1984, at ¶3. It is intended to describe the impact of the pre-NYPHRM hospital/self-insured health plan agreements continued under the PHL § 2807-a(6)(b)(ii) exception to the equal charges requirement and of the agreements protected by the district court injunction that was briefly in effect. *Ibid.* It relies on the accountant's "experience," over an unspecified period of time, with "20 or so" unidentified hospitals of the three hundred hospitals in the state. *Ibid.* As appears, the figure is not reliable for the purpose it was offered below and cannot be accepted as a prospective measure of the statewide impact of continuing deregulation.

The petition (at 5 n.3) misrepresents the record when it claims that the state's opposition to the equal charges requirement reflects an animus against self-insurers rather than an interest in implementing NYPHRM's assurance that hospitals receive sufficient inpatient income from rates and equal, not discount, charges. See pp. 2-3, 4 n.**, 6-10. The state official the petition quotes in part (at 5 n.3) expressed concern about the economic consequences that would follow the negotiation of discount charges between hospitals and self-insured health plans under deregulation. A. 391 ¶14 and pp. 8-10. As the official notes (A. 391 ¶14), the consequences of concern result from the discounts plans receive, not from their self-insured status. Indeed, under New York law, employee welfare plans are "encouraged" because of their "great benefit to employees and their families." Insurance Law § 4401(a). See p. 4 n.*.

non-profit health insurers would collapse, diminishing the insurers capacity to provide policies to the public at large, and placing the cost of health care for individuals who are ineligible for group plans and cannot afford individual commercial policies on the public fisc. See p. 4 n.**.

B. The United Optical Workers' ERISA-Covered Employee Welfare Plan

The United Optical Workers Insurance Fund maintains an employee welfare plan under § 4(a) of the Employee Retirement Income Security Act of 1974 ("ERISA" or "the Act"), 29 U.S.C. § 1003(a). Petition at 2. ERISA authorizes these plans, which may be administered by employers or employees, or both, to provide a variety of employee benefits, including medical, accident disability and death benefits, unemployment and vacation benefits, training programs, scholarship funds, prepaid legal services and day care. ERISA § 3(1), 29 U.S.C. § 1002(1). *See generally Franchise Tax Board of California* v. *Construction Laborers Vacation Trust for Southern California,* 679 F.2d 1307 (9th Cir. 1982), *vac. and remanded on jurisdictional grounds,* 103 S. Ct. 2841, 2843-45 (1983) (employee welfare plan, providing vacations, claims ERISA preemption of state tax levies). *Contrast* petition at 10, stating that the "sole function and purpose [of] an employee welfare plan is to provide hospital care or benefits," seeming to claim that all benefits must be hospital-related.

The United Optical plan is administered jointly by employers and employees (A. 18 ¶1) but relies entirely on employer contributions, negotiated in collective bargaining. A. 19-20 ¶3. *Contrast* petition at 3, stating that employer contributions are the "primary source" of plan funding without identifying any other sources. The plan provides accident, disability (stipend if at home because of accident or illness) and death benefits, in addition to medical benefits, which include paid doctor vists and laboratory fees, standard major medical coverage and all hospital expenses for up to one hundred and twenty days of care. A. 22. Fifteen

hundred individuals, employee plan members and their dependents, in five states, New York, New Jersey, Connecticut, Massachusetts and Florida, are eligible for the benefits. A. 18-19, ¶¶1, 2.* Three of the states in which the plan operates, New York, New Jersey and Massachusetts, have experimental NYPHRM programs. Opinion below at 6a; *see generally Massachusetts Nurses Association* v. *Dukakis*, 726 F.2d 41, 42, 45-46 (1st Cir. 1984) (hospital inpatient income controls, alleged to interfere with collective bargaining, upheld against NLRA preemption claim).

Effective January 1, 1983, the trustees of the United Optical plan decided to self-insure, a choice ERISA leaves to their discretion. ERISA § 3(1), 29 U.S.C. § 1002(1) (employee welfare plans may provide authorized benefits "through the purchase of insurance or otherwise," *e.g.* through self-insurance). A. 19-20 ¶3. The trustees then terminated United Optical's contracts with Blue Cross plans that had insured its inpatient services benefits and retained an agent to represent the plan's interests as a self-insurer. A. 20 ¶3a, 29 ¶8.** The agent represented some

* The petition (at 2) characterizes United Optical plan members and their dependents as "medically indigent." The term is normally confined to individuals who receive public medical assistance, *i.e.* Medicaid, but are not eligible, because of excess income and resources, for other public assistance programs, *e.g.* Aid to Families with Dependent Children, which address more generalized needs. The petition (*ibid.*) concedes that United Optical plan members earn too much money to be Medicaid-eligible. Notwithstanding this concession, the petition (*ibid.*) claims that the members of the United Optical plan would leave their hospital bills unpaid if plan benefits were withdrawn or reduced. The petition does not explain why they would do so, and the result appears unlikely, given the availability, in New York, of individual health insurance policies from non-profit insurers at modest cost. See p. 4 n.**.

** According to the United Optical plan's agent, self-insured health plans realize economies on inpatient services benefits in five ways, which he does not distinguish in importance: a) negotiating price discounts with hospitals; b) keeping reserve funds in an interest-bearing account; c) conducting case reviews to eliminate unnecessary medical procedures and reduce lengths of stay; d) coordinating benefits and collections with other insurers; and e) reducing administrative costs. A. 26-28 ¶¶4-8.

fifty self-insured ERISA health plans when United retained him, and, negotiating with hospitals for the plans as a block, had obtained about one hundred discount agreements. A. 26 ¶4 (data in record not exact). Most of the agreements were five percent above the hospitals' rates for Blue Cross plans and other non-profit health insurers; the rest were for lower discounts or no discounts. A. 20 ¶3(a); 26 ¶5 (data in record not exact). *Contrast* petition at 4, 12 n.9, claiming that all one hundred agreements were for discounts of five percent above the non-profit insurer rate. To the extent United Optical's agent obtained discounts for the fifty self-insured plans he represented, the charges of other charge payors, to whom hospitals shifted their losses, increased See pp. 7, 8-9.

For 1983, the United Optical plan's first year as a self-insurer, its agent projected savings of $100,000 to $120,000 from all self-insurance-related economies (see p. 11 n.**), including United Optical's participation in the discount agreements. Petition at 4; A. 26-27 ¶5. Notwithstanding anticipated savings from self-insurance, United incurred losses from its medical benefits in 1983, and, before January 1, 1984, the effective date of NYPHRM's equal charges requirement (PHL § 2807-a[6][¶1]), plan trustees reduced non-hospital medical benefits. A. 29 ¶3(a). See petition at 3, noting that United's hospital benefits remained the same under self-insurance but omitting the fact the plan's non-hospital medical benefits were reduced.

C. Proceedings In The District Court And The Opinion Below

Petitioner commenced this action in the United States District Court for the Southern District of New York on December 1, 1983 (A. 2 [12/1/83 entry]), a month before NYPHRM's equal charges requirement became effective. PHL § 2807-a(6) (¶1). He sought declaratory and injunctive relief against the equal charges requirement, § 2807-a(6) (A. 12-13 ¶¶1, 2), claiming that if it were enforced, the United Optical plan would have to reduce

benefits, forego its recently adopted status as a self-insurer and return to purchasing insurance from Blue Cross plans. Petition at 5; see also A. 12 ¶24.*

The action was initially submitted to the district court on petitioner's motion for a preliminary injunction. A. 14. The motion relied on the multiple legal theories set forth in the complaint. A. 8-11 ¶¶12-22.** However, at the suggestion of the court and with consent of the parties and the *amicus curiae*, Blue Cross and Blue Shield of Greater New York, the moving and opposing papers were read as cross-motions for summary judgment on the question of whether PHL § 2807-a(6) was preempted by ERISA § 514(a), 29 U.S.C. § 1144(a), because it required hospitals to bill United Optical's ERISA-covered, self-insured health plan equal charges. District court opinion at 40a ¶1.

* Petitioner has yet to explain why these presumed consequences follow the enforcement of NYPHRM's equal charges requirement. Their brief examination reveals that they do not and that petitioner is really describing some, but not all, of the United Optical plan's options in straightened economic times, not the consequences of state action. For example, the United Optical plan need not reduce benefits even if the prohibition against new discount agreements established by equal charges requirement yields increased costs, a result itself in doubt. See pp. 11 n.**, 12. The plan trustees may choose to reduce benefits, as they did in 1983, before the equal charges requirement had any application. See p. 13. Alternatively, the trustees may choose to supplement the employer contributions that now fund all plan benefits (see p. 10) with employee contributions, an option petitioner has not yet noted, and a low-cost device, routinely adopted by employee welfare plans, to maintain benefit levels. Equally, United's trustees may, but need not, forego self-insurance, albeit there is no reason for them to do so since they have been advised that self-insurance allows economies that have no relation to discount agreements. See p. 11 n.**. If the plan trustees decide to purchase insurance, they may buy it from Blue Cross plans or any other health insurer. It may even be to trustees' advantage to seek out a commercial insurer, which while subject to the equal charges requirement, competes with Blue Cross plans by offering low premiums on experienced-rated group policies the plan would buy. See p. 4 n.**; A. 106 ¶26.

** The complaint alleged claims for relief under the contracts clause, the interstate commerce clause, the equal protection clause, the anti-trust laws and ERISA. Petitioner recently withdrew, with prejudice, all of the recited claims except the anti-trust claim and the ERISA preemption claim that is now before this Court. Stipulation dated March 25, 1985.

The district court issued its opinion and order on March 12, 1984. The court held that PHL § 2806-a(6) was preempted by ERISA because it "relate[d] to" the United Optical plan under § 514(a) of the Act, 29 U.S.C. § 1144(a), and was not saved by the ERISA exceptions from preemption for state laws regulating insurance, § 514(b)(2)(A), 29 U.S.C. § 1144(b)(2)(A), and for interpretations of § 514 (a) that would impair other federal laws. § 514(d), 29 U.S.C. § 1144(d). District court opinion at 23a-39a.* The court's finding that the equalized hospital charges PHL § 2807-a(6) requires "relate[d] to" the plan under § 514(a) relied, principally, on the broad reading this Court gave that language in *Shaw* v. *Delta Air Lines, Inc.*, 463 U.S. 85, 103 S. Ct. 2890 (1963). District court opinion at 23a-27a. ERISA's legislative history, as set forth in *Delta Air Lines*, and ERISA § 514(c)(2), 29 U.S.C. § 1144(c)(2), defining state and local entities whose laws are subject to ERISA preemption, or state and local laws that ERISA preempts, as those purporting "to regulate, directly or indirectly, the terms and conditions of [ERISA-covered] employee . . . [welfare] plans," are cited as supporting the court's conclusion. District court opinion at 23a-24a, 25a.

The district court also identified two supposed ERISA § 514(a), 29 U.S.C. § 1144(a), 'relationships' between the equal charges requirement and the United Optical plan: increased plan cost or reduced plan benefits allegedly caused by equal charges (district court opinion at 25a-26a; but see pp. 11 n.**, 12, 13 n.*); and frustration of ERISA's goal of uniform, multistate administration allegedly caused by equal charges. District court opinion at 24a-25a, 38a. A third point, the alleged specificity of PHL § 2807-a(6) in prohibiting hospitals from entering into new, *i.e.* post-January 1, 1984, charges agreements with self-insured health plans was also noted. *Id.* at 26a-27a.

* We do not summarize the district court's examination of PHL § 2807-a(6) under the state insurance law and impairment of other federal laws exceptions from ERISA preemption because they are not reached by the opinion below. See district court opinion at 28a-38a.

On November 26, 1984, a unanimous panel of the United States Court of Appeals for the Second Circuit reversed the district court. Opinion below at 1a-16a. At the outset of its opinion, the court acknowledges that the spiraling cost of hospital care has been a serious public problem for several decades. *Id.* at 3a. It then traces the history of the more and less successful cost containment efforts, respectively, of Medicaid and Medicare (*id.* at 4a-5a) and the federal government's interest, since at least 1967, in experimenting with state methodologies that increase efficiency without impairing quality of care. *Id.* at 5a. See pp. 2 n.*, 6 & n.*. The court concludes its history by noting the most recent state-federal effort, NYPHRM, and the four similar demonstration projects in other states. *Id.* at 6a-7a, 15a. NYPHRM is described as an exercise of the state's police power (opinion below at 10a), approved by HHS and ratified by Congress (*id.* at 6a), whose equal charges requirement fairly and flexibly apportions cost, free of the administrative difficulty of establishing specific rates for all inpatient services. *Id.* at 15a-16a.

When the court turns to the text of ERISA, it finds initial assistance for interpreting § 514(a), 29 U.S.C. § 1144(a), in § 514(c)(2), 29 U.S.C. § 1144(c)(2), the same subsection cited by the district court in support of the preemption of PHL § 2807-a(6). See p. 14. The Court of Appeals reads subsection § 514(c)(2) as referring to the state and local laws ERISA preempts (rather than to state and local law-making bodies whose laws ERISA may preempt) and as limiting the preempted laws to those that regulate the "terms and conditions" of covered plans. § 514(c)(2); opinion below at 9a & n.1. *Alessi* v. *Raybestos-Manhattan, Inc.*, 451 U.S. 504, 525 (1981), is cited as supporting the court's reading of § 514(c)(2), and the use of that subsection in interpreting § 514(a).*

* The court later describes the state and local laws preempted by § 514(a), 29 U.S.C. § 1144(a), more broadly, *i.e.* as laws that affect "the structure, the administration or the type of benefits provided by an ERISA plan . . . ." Opinion below at 12a. See petition at 9-10, criticizing the court's reference to the "terms and conditions" language in § 514(c), 29 U.S.C. § 1144(c), but omitting mention of the court's later reference to "structure," "administration" and "type of benefits."

The court next acknowledges the broad reading this Court gave the "relate to" language in *Shaw* v. *Delta Air Lines, Inc.*, 463 U.S. 85, 103 S. Ct. 2890 (1983), as well as the limitations imposed on that language by *Delta Air Lines*, i.e. state laws that affect plans in a tenuous, remote or peripheral manner do not "relate to" plans. 103 S. Ct. at 2901 n.21. Opinion below at 10a, 11a-12a. It then concludes that the PHL § 2807-a(6) equal charges requirement has, at best, a remote effect on plans, within the limitations on § 514(a) expressed in *Delta Air Lines*, and, therefore, does not "relate to" plans for purposes of ERISA preemption. Opinion below at 10a.*

The court addresses, and rejects as insufficient, the three considerations the district court thought established an ERISA § 514(a), 29 U.S.C. § 1144(a), 'relationship' between PHL § 2801-a(6) and the United Optical plan. Opinion below at 11a-13a. See p. 14. Increased costs (or reduced benefits to offset them) are recognized as a possible consequence of all state and local regulation, whether of hospital charges or telephone rates, from which

* The petition (at 9, 11) claims, wrongly, that the court held PHL § 2807-a(6) free of ERISA preemption on the erroneous premise that it had to do so unless it found an unavoidable conflict between the state statute and a "term" or "condition" of the United Optical plan. See also Central States *amicus curiae* brief at 7, 8. The court's statement on point is: "[A] state's promulgation of hospital rate schedules [, *i.e.* equal charges,] should not be found to 'relate' to 'the terms and conditions of employee benefit plans' unless this conclusion is unavoidable." Opinion below at 11a. *Alessi* v. *Raybestos-Manhattan, Inc.*, 451 U.S. 504, 522 (1981), is cited. *Ibid.*

The statement does not depend on an erroneous premise. *Alessi* held a state statute preempted by ERISA on a traditional preemption-by-implication analysis, which, as the opinon below observes (at 11a), found the statute and federal law in "unavoidable" conflict. 451 U.S. at 522. *See Shaw* v. *Delta Air Lines, Inc.*, 103 S. Ct. at 2900 n.15, noting distinction between the express preemption analysis under § 514(a) pursued there and the *Alessi* by-implication analysis. To the extent that court's brief statement may be read as a preemption-by-implication analysis and a finding that PHL § 2807-a(6) is not preempted, it is not error. It simply reflects the court's undertaking of the *Alessi* analysis, in addition to the *Delta Air Lines* analysis, on which its express holding depends. The holding, stated in the text just above, relies exclusively on the *Delta Air Lines*, citing the attentuated effect of § 2807-a(6) on ERISA-covered plans.

ERISA plans have no special protection. Opinion below at 11a-12a. ERISA's goal of national uniformity is recognized as serving plan interests in the discretionary choice of form of administration and benefits, not in nationwide uniformity of price, a goal which United Optical's preference for negotiated charges would not serve in any event. *Id.* at 12a-13a. The PHL § 2807-a(6)(b)(ii) reference to pre-NYPHRM negotiated agreements, *i.e.* "payment . . systems," that are permitted to continue after the January 1, 1984 effective date of the equal charges requirement, is recognized as a legislative effort to temper the treatment of self-insured health plans to reflect differences among them or between them and other charge payors. *Id.* at 12a n.2.*

One Circuit Judge on the Court of Appeals panel, writing for himself, believed that PHL § 2807-a(6) would also be saved from ERISA preemption by the § 514(d), 29 U.S.C. § 1144(d), exception for interpretations of §514(a), 29 U.S.C. § 1144(a), that would impair other federal laws. Opinion below at 13a-16a. According to the Judge, a federal statute, § 402(a), (b) of the Social Security Amendments of 1967, 42 U.S.C. § 1395b-1(a)(C), (b), authorizing the HHS secretary to grant Medicare waivers for experimental programs involving state methodologies, the authority for New York's NYPHRM waiver (A. 220-24), would be impaired if § 2807-a(6) were preempted for hospital charges to ERISA-covered, self-insured health plans.

The Writ Should Be Denied

The Decision Below Is Correct Because ERISA-Covered Employee Welfare Plans And NYPHRM's Equal Charges Requirement Cannot Relate To Each Other Under ERISA § 514(a). There Is No Conflict With Decisions Of This Court Or With Decisions From The Circuits On This Point.

ERISA and NYPHRM, including the PHL § 2807-a(6) equal charges requirement in issue, regulate within dis-

* Record references cited at p. 5 n.** include the joint appendix references, A. 141 ¶2, 162 ¶11, which the petition (at 9 n.5) suggests, wrongly, disclose a different or more intense state interest in regulating self-insured health plans.

crete fields that cannot "relate to" each other under § 514 (a) of the Act, 29 U.S.C. § 1144(a). ERISA, through Congress' commerce clause power, regulates the field of covered, *i.e.* non-exempt, employee pension and welfare plans.* ERISA establishes rights and relationships among employee welfare plan managers, plan members and fiduciaries and standards for reporting, disclosure and fiduciary responsibility. ERISA §§ 101-110, 401-413, 29 U.S.C. §§ 1021-1030, 1101-1113. ERISA authorizes a variety of welfare plan benefits, *e.g.* medical and vacation benefits, scholarships, day care, from which a plan may select some or all (§ 3[1], 29 U.S.C. § 1002[1]); it permits plans to provide the benefits "through the purchase of insurance or otherwise," *e.g.* through self-insurance (*ibid.*); and, subject to the few legislatively-mandated practices noted, *e.g.* reporting and disclosure, it generally reserves matters of plan design to the representatives of employers, employees, or both, who manage the plan, and, ultimately, to plan funding, determined through collective bargaining. *See* ERISA §3 (1), 29 U.S.C. § 1002(1) (employers, employees, or both, may administer covered plans); *Alessi* v. *Raybestos-Manhattan, Inc.*, 451 U.S. 504, 511, 525 (1981) (most choices for more intensely regulated pension plans left to private parties); and p. 11 (United Optical employee welfare plan benefits, administration and funding described).

ERISA has a unique feature. Under § 514(a), 29 U.S.C. § 1144(a), it expressly preempts state laws that "relate to" covered employee pension and welfare plans, rather than, as might be anticipated, state laws that "relate to" sections of the Act. Section 514(a) was adopted in this form, after extended deliberation, to protect from state interference both the subjects on which ERISA affirmatively legislates

* Certain employee pension and welfare plans are exempt from ERISA, principally those maintained by churches or by governments for their own employees or to comply with Workers Compensation and Unemployment Insurance laws. ERISA § 4(b), 29 U.S.C. § 1003(b).

and the subjects it reserves to plan discretion.* *Shaw* v. *Delta Air Lines, Inc.*, 463 U.S. 85, 103 S. Ct. 2890, 2900-2901, esp. n.18-n.20 (1983).

NYPHRM is an experiment in financing hospital inpatient services, created by the New York Legislature under its police power and a federal waiver of authority over Medicare rates granted by the United States Department of Health and Social Services. See pp. 2-3. The program, which expires on December 31, 1985, affirmatively controls all of the inpatient income of the three hundred general hospitals in the state. See p. 1. It does so through three essential components—inpatient revenue caps (PHL § 2807-a[1]-[4]), inpatient rates (§§ 2803[2], 2807[2],[3], 2807-a [1] with complementary equal charges (§ 2807-a[6]), and contributions to offset losses from bad debts and charity care (§ 2807-a[1],[9])—all established or approved by state agencies, or, for the equal charges requirement in issue (§ 2807-a[6]), by hospitals under state-established standards. See pp. 2 n.*, 3 n.‡. The equal charges requirement obligates each general hospital to bill its non-rate, charge payors at the same per service price. PHL § 2807-a(6) (¶1). Subject to two minor exceptions (see pp. 4-5), it also obligates each hospital to establish its charges at a level which, when added to its rates, is sufficient to meet its inpatient income needs and is at a certain interval above its

* Respondents give the broadest possible meaning to the term "subject." It includes any matter on which ERISA has affirmatively legislated, and any matter a covered plan is empowered to decide, with or without recourse, to the Act. Given this definition, it is unnecessary to now decide whether the phrase, "purports to regulate, directly or indirectly, the terms and conditions of employee . . . [welfare] plans," in ERISA § 514(c)(2), 29 U.S.C. § 1144 (c)(2), refers to state and local laws ERISA preempts or to state and local entities whose laws ERISA may preempt. See opinion below at 9a & n.1 and pp. 14, 15. It is also unnecessary to decide whether "terms and conditions" refers to matters literally set forth in covered plans, *e.g.* the benefits they provide, or to those matters and, in addition, plan structure, administration and choice of benefits. See opinion below at 12a and p. 15. See also petition at 10; Local 338 *amicus curiae* brief at 10; Blue Cross *amicus curiae* brief at 8.

recent non-profit health insurer rate. *Id.* at § 2807-a(6)(a), (b) and pp. 4-5.*

The PHL § 2807-a(6) equal charges requirement cannot "relate to" ERISA, to the United Optical plan, or to any other ERISA-covered, employee welfare plan, whether self-insured or not, under ERISA § 514(a), 29 U.S.C. § 1144(a), because the state statute regulates a subject—hospital prices for inpatient services—that is outside ERISA's field of regulation.** ERISA has not affirmatively legislated the price of inpatient services, and employee welfare plans cannot decide the price of these services through the exercise of the discretion ERISA reserves to them. Indeed, the plans are in the same position with respect to inpatient services under ERISA as they were before ERISA. In neither circumstance, could they decide the price of the services. NYPHRM's control over the price of inpatient services, through state-established or approved rates and the complementary PHL § 2807-a(6) equal charges require-

* Non-profit health insurers, *e.g. amicus curiae* Blue Cross and Blue Shield of Greater New York, receive differentials, *i.e.* discounts, of twelfe to fifteen percent below the equal charges level. See p. 4 n.**.. The discounts are justified by the non-profit insurers' obligation to issue policies to the public at reasonable cost, and their need to subsidize these policies with the proceeds from the sale of group health insurance policies which they sell in competition with commercial insurers. *Ibid.* ERISA-covered plans do not share the non-profit insurers' obligations, and so discounts for them, neogtiated or otherwise, are not justified. However, since ERISA preemption depends on the exercise of power, here whether the state can regulate the price of impatient services, not its degree, *i.e.* what the regulated price of inpatient services is, the fact that covered plans pay equal charges while non-profit health insurers pay less is irrelevant in this case. Respondents have, therefore, restyled the question presented to omit the petition's reference (at i) to non-profit health insurer discounts.

** To "regulate" means to fix, establish or control; . . . to direct by rule or restriction; to subject to governing principles or laws." Black's Law Dictionary at 1156 (5th ed. 1979). ERISA's field of regulation, therefore, encompasses any matter it can "subject to governing principles" and, by extension, any matter its covered-plans have the power to "establish" or decide. *Ibid.* Hospital prices for inpatient services are not among the matters ERISA can govern, or covered plans can decide.

ment, reciprocates the lack of price control authority by ERISA and ERISA-covered plans, and places the subject of price firmly and exclusively within the field of NYPHRM regulation.*

The reciprocal relationship between the ERISA and NYPHRM fields of regulation with respect to the price of inpatient services applies, in reverse, to inpatient services as employee welfare plan benefits. The relationship is readily illustrated and places the subject of inpatient services as plan benefits outside the field of NYPHRM regulation and firmly and exclusively within the field of ERISA regulation. NYPHRM does not legislate, *i.e.* mandate, inpatient services as plan benefits, and hospitals cannot decide that inpatient services will be plan benefits in the exercise of the discretion NYPHRM reserves to them. Hospitals, before and after NYPHRM, are in the same relation to inpatient services as plan benefits, as are plans, in relation to the price of inpatient services before and after ERISA, *i.e.* without any regulatory authority. As the plans' lack of authority over the price of inpatient services and NYPHRM's control over it place price outside the field of ERISA regulation and within the field of NYPHRM regulation, so the hospitals, now NYPHRM's, lack of authority over inpatient services as plan benefits, and the plans' control over them as benefits place this aspect inpatient services outside the field of NYPHRM regula-

* That hospitals and plans could negotiate the price of inpatient services before NYPHRM does not mean that price was then decided by plans, *i.e.* was within ERISA's field of regulation. The pre-NYPHRM power to decide the price of inpatient services for plans and other charge payors resided with hospitals. The hospitals power over the subject is evidenced by three facts: 1) no negotiated charges agreement could be concluded without a hospital's acquiescence, or consent, or in face of its refusal to agree; 2) if a hospital refused to negotiate or to agree, plans and other prospective price negotiators were bound to pay charges the hospital established unilaterally; and 3) the hospital could revise its charges, but the plans and other prospective negotiators could not compel it to do so. NYPHRM succeeded to the hospital's power to decide charges and, in effect, directs them, under PHL § 2807-a(6) (with the two exceptions noted at pp. 4-5), to refuse to negotiate.

tion and within the field of ERISA regulation. In sum, ERISA and NYPHRM operate within discrete fields of regulation with respect to two different aspects of inpatient services. ERISA-covered plans can decide whether inpatient services will be plan benefits but not their price. NYPHRM can decide the price of inpatient services but not whether they will be plan benefits.

Respondents' analysis, limiting the preemptive reach of the term "relate to" in ERISA §514(a), 29 U.S.C. §1144(a), to ERISA's field of regulation, and leaving state laws, like PHL § 2807-a(6), intact because they are outside that field, is consistent with the discussion of the term "relate to" in *Shaw* v. *Delta Air Lines, Inc.*, 463 U.S. 85, 103 S.Ct. 2890, 2900-2901 (1983). There, this gives Court "relates to" its normal meaning which is "connection with or reference to." *Id.* at 2900. The Court then identifies ERISA as " 'regulat[ing] the field of employee benefit plans' " (*id.* at 2901 [quoting legislative history]; *see also id.* at 2901 n.20), and limits the word "connection" to connection with ERISA-covered plans (*id.* at 2900). *Contrast* petition at 25, noting the Court's initial definition but omitting the further elaboration. The only conclusion available from the Court's discussion is the one respondents have drawn. Namely, only state laws that have an ERISA-field "connection" or a covered-plan "connection" come within the term "relate to" in § 514(a).

To the extent that respondents' analysis also requires the state law "connection" to ERISA's field of regulation or to covered-plans to involve a subject which ERISA regulates or plans can decide, it observes a point of law cited by the Court in *Delta Air Lines.* Only state laws that have a cognizable connection to ERISA or to covered-plans come within the term "relate to" and are preempted by § 514(a), 29 U.S.C. § 1144(a). 103 S.Ct. at 2901 n. 21. *See Franchise Tax Board of California* v. *Construction Laborers Vacation Trust for Southern California,* 679 F.2d 1307, 1313 (*Tang,* C.J. dissenting) (9th Cir. 1982), *vacated remanded on jurisdictional grounds,* 103 S.Ct. 2841 (1983) (state laws

must have a "regulatory effect" on plans to be preempted); *Local Union 212* v. *Local Union 212 IBEW Credit Union*, 549 F. Supp. 1299, 1302 (S.D. Ohio 1982) (same). Conversely, state laws, like PHL § 2807-a(6), without a cognizable connection to ERISA or to covered plans, *i.e.* those which do not regulate subjects that ERISA legislates or plans can decide, do not "relate to" plans and are not preempted by § 514(a) although they may effect plans, *e.g.* they may result in increased cost or reduced benefits. *See Shaw* v. *Delta Air Lines, Inc., supra*, and cases cited just above; *American Progressive Life and Health Insurance Co.* v. *Corcoran*, 715 F.2d 784, 787 (2d Cir. 1983) (state law establishing commissions on sales of life insurance policies saved from ERISA preemption under the exception for state insurance laws, and law's slight effect plan benefits held not sufficient to warrant its characterization as "govern[ing]" plans); and *Group Life & Health Insurance Co.* v. *Royal Drug Co.*, 440 U.S. 205 (1979) (Blue Shield/pharmacy price agreements affecting insureds' benefits held not to involve the business of insurance because, *inter alia*, the pharmacies were non-insurance-related, third parties, the same status hospitals have in relation to covered plans under PHL § 2807-a[6]).

Indeed, were state laws capable of preemption under ERISA § 514(a), 29 U.S.C. § 1144(a), only because, as the petition (at 20-21, 23 n.17) claims, they have an economic effect on covered plans, two extraordinary and anomalous consequences would follow. First, as the opinion below observes (at 10a, 11a-12a), plans would obtain an economic advantage over all other purchasers of goods and services because they would be immunized from state and local price and wage controls in myriad transactions, including paying for plan utilities, plan employees and plan benefits.*

* The petition (at 10, 21) attempts to confine its economic effect theory of ERISA preemption to payments for plan benefits, which it characterizes as the "business" of the plans (*id.* at 21), as distinguished from payments for plan utilities, employee salaries, and the

(footnote continued on next page)

Second, subjects commonly addressed by state and local action would be immune from regulation to the extent they involve plans. For example, if state and local laws regulating utility rates and minimum wages are preempted under § 514(a) because the amount of plan telephone bills and plan employee salaries establish a 'relation' between the laws and plans, the subjects of the laws, telephone rates and minimum wages, become nonregulable with respect to plans. They become so because the decisions of the state and local agencies that are empowered to act on rates and wages have been nullified by 514(a) and, given ERISA's field of regulation is limited to subjects ERISA legislates and plans can decide, no substituted rates or minimum wage standards can be provided by plans. As noted (p. 23 n.*), if preemption of state and local laws under § 514(a) depends on economic effect, a plan's payment for benefits is indistinguishable from its payment of the telephone bill or the salaries of its employees. Thus, the same result obtains when plans pay regulated prices for benefits like inpatient services, college tuition or day care.* If the state or local

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like, which it accepts as the 'cost of doing plan business.' *Id.* at 10. *See also* Central States *amicus curiae* brief at 9. The distinction is a false under petition's own theory. A plan's payment for any good or service, whether the telephone bill or inpatient services, is an expenditure of plan funds with, perforce, an economic effect on the plan. Accordingly, if, as the petition (at 20-21, 23 n.17) contends, state laws are preempted by ERISA § 514(a), 29 U.S.C. § 1144(a), because of their economic effect on plans, a law that regulates telephone rates is preempted to the same extent as a law that regulates the price of inpatient services. Notably, to the extent either or both laws increase plan expenditures, which are not offset by increased income, the plan must undertake economies, including possible reductions in plan benefits.

* ERISA-covered plan benefits are not confined to hospital benefits as the petition (at 10, 21) suggests, but may include scholarships and day care among others. ERISA § 3(1), 29 U.S.C. § 1002(1) and p. 10. Thus, even if the petition's attempted limitation of ERISA preemption to plan payments for benefits, as distinguished from plan payments for other costs, were followed (see p. 23 n.*), plans would receive wide-ranging immunity from price controls and numerous subjects commonly addressed by state and local action

(footnote continued on next page)

law is preempted under § 514(a), the subject becomes non-regulable because plans cannot decide the price of the benefits in lieu of the duly constituted state and local agencies.

The petition cites two decisions of this Court, *Shaw* v. *Delta Air Lines, Inc.*, 463 U.S. 85, 103 S.Ct. 2890 (1983), and *Alessi* v. *Raybestos-Manhattan Inc.*, 451 U.S. 504 (1981), which have upheld the preemption of state laws under ERISA § 514(a), 29 U.S.C. § 1144(a), four decisions from the Circuits that have done so,* and a matter now before this Court, *Metropolitan Life Insurance Co.* v. *Massachusetts*, No. 84-325, on which the petition (at 11-13) principally relies, where the outcome necessarily is in doubt.** None of

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would be immunized from regulation. For example, plan scholarships at state universities would be immunized from state-established tuition; plan payments for public day care would be immunized from locally established charges; and, in neither case, could a plan establish charges for the services in lieu of the state or locality.

* *Stone & Webster Engineering Corp.* v. *Ilsley*, 690 F.2d 323 (2d Cir. 1982), *aff'd sub nom., Arcudi* v. *Stone & Webster Engineering Corp.*, 103 S. Ct. 356 (1983) (statute mandating employer contributions for life and health insurance for former employee preempted); *Standard Oil of California* v. *Agsalud*, 633 F.2d 760 (9th Cir. 1980), *aff'd*, 454 U.S. 801 (1981) (statute mandating employers to provide prepaid comprehensive health care benefits preempted); *Pervel Industries* v. *Connecticut Commission on Human Rights and Opportunities, aff'd*, 609 F.2d 214 (2d Cir. 1979), *cert. denied*, 443 U.S. 1031 (1980) (statute mandating pregnancy disability benefits preempted); *Hewlett-Packard Co.* v. *Barnes*, 425 F. Supp. 1294 (N.D. Cal. 1977), *affd*, 571 F.2d 502 (9th Cir.), *cert. denied*, 439 U.S. 831 (1978) (statute comprehensively regulating health care service plans, including same subjects as ERISA, preempted; statute's regulation of third party health care providers, *e.g.* hospitals, not in issue, 425 F. Supp. at 1297 n.10).

** The petition (at 12, 13) claims similarities between *Metropolitan* and this case sufficient to make their outcomes in this Court depend on each other. The two cases have virtually nothing in common. *Metropolitan* involves a Massachusetts statute that requires health insurance policies to include minimum coverage for certain mental and nervous disorders. The statute is challenged as ERISA-preempted by covered plans that purchase health insurance on the theory that it mandates plan benefits. It is defended by Massachusetts solely on the ground that it is a law regulating insurance and saved from preemption under the ERISA exception for those state laws. ERISA § 514(b)(2)(A), 29 U.S.C. § 1144(b)(2)(A).

(footnote continued on next page)

the decisions provides authority for the preemption of PHL § 2807-a(6) by § 514(a), or is in conflict with the decision below, because none considers a state law that regulates the price of a good or service plans buy, whether as a plan benefit, like the inpatient services regulated as to price by § 2807-a(6), or for any other purpose. See pp. 23 n.*, 24 n..**

Brief for Appellee at i, 12-34. PHL § 2807-a(6), the statute involved in this case, regulates the price of inpatient services. The statute does not mandate plans to provide the services as benefits. It was held free of ERISA-preemption below under § 514(a), 29 U.S.C. § 1144(a), not, as the petition (at 12) states, saved from § 514(a) preemption by "an expansive interpretation of the [ERISA] exceptions to preemption." See also *id.* at 18. As appears, *Metropolitan's* disposition depends on the status of the Massachusetts statute as an insurance law under § 514(b)(2)(A) and, whatever the outcome, the status of PHL § 2807-a(6) as a price control regulation under § 514(a) will not be affected. *Contrast* petition at 13.

The petition (at 12-13 & n.10) is also mistaken when it claims that differences between the Massachusetts and New York laws make it "virtually impossible" (*id.* at 13 n.10) to operate the United Optical plan in the same manner in the two states. New York, like Massachusetts, requires minimum coverage in health insurance policies. Insurance Law § 4303. See also Central States *amicus curiae* brief at 5-6. Thus, the incentive for plans to self-insure that the petition (at 12 & n.10) attributes to Massachusetts, *i.e.* avoidance of mandated minimum coverage, is also present in New York. Second, Massachusetts is a NYPHRM state (see pp. 10-11), and its non-profit health insurer rate is the same as all other payor rates and charges. *Massachusetts Nurses Association* v. *Dukakis*, 726 F.2d 41, 45-46 (1st Cir. 1984). Thus, the incentive for plans to purchase non-profit insurance the petition (at 12 & n.10) attributes to New York because of its non-profit insurer differentials does not become a dis-incentive in Massachusetts. Notably, three of the five states in which the United Optical plan operates have NYPHRM programs, *i.e.* New York, New Jersey and Massachusetts, substantially facilitating the plan's uniform, interstate operation. See pp. 10-11.

* Two of the four Circuit decisions the petition cites, *Stone & Webster Engineering Corp.* v. *Ilsley*, *supra*, and *Pervel Industries* v. *Connecticut Commission on Human Rights and Opportunities*, *supra*, like the decision below, are from the Second Circuit. They cannot support the conflict among the Circuits on the question presented that the petition (at 15-25) claims even if they opposed the decision below. Of the two other Circuit cases the petition cites, one, *Standard Oil of California* v. *Agsalud*, *supra*, involved comprehensive mandatory benefits, not the regulation of the price their third party providers charged, and the other *Hewlett-Packard Co.* v. *Barnes*, *supra*, disclaimed any consideration of third party providers.

All of the decisions the petition cites conform with respondents' analysis (see pp. 20-23) because the state laws held preempted by ERISA § 514(a), 29 U.S.C. § 1144(a), regulated subjects within ERISA's field of regulation, *i.e.* subjects ERISA legislates* or subjects ERISA reserves to the discretion of covered plans.** None of the decisions opposes the premise of respondents' analysis that characteristics that include state laws within ERISA's field of regulation—ERISA legislation and plan discretion—also exclude state laws from that field. Thus, none opposes respondents' conclusion, establishing § 2807-a(6) free of preemption by § 514(a), because ERISA does not legislate and plans cannot decide the price of inpatient services. Indeed, since five of the seven decisions the petition cites involve state laws that were preempted because they mandated plan benefits,† the decisions illumine the line drawn by respondents' analysis that places those state laws firmly and exclusively within ERISA's field of regulation. See pp. 21-22.

The petition (at 9 ,12, 14, 19) puts aside the text of PHL § 2807-a(6) and the statute's role in NYPHRM when it claims that the state law "relates to" ERISA-covered employee welfare plans under § 514(a), 29 U.S.C.

* *Hewlett-Packard Co.* v. *Barnes, supra.*

** *Alessi* v. *Raybestos-Manhattan, Inc., supra,* and *Shaw* v. *Delta Air Lines, Inc., supra,* are typical of the decisions the petition cites holding state laws that interfere with plan discretion preempted by § 514(a). *Alessi* preempted a state law that eliminated a method of calculating pension benefits which, absent the law, plans could use or not, as they chose. *Delta Air Lines* preempted a state law that mandated pregnancy disability benefits which, absent the law, plans could provide or not, as they chose. The state laws involved in the four other decisions the petition cites were to the same effect, *i.e. Metropolitan Life Insurance Co.* v. *Massachusetts, supra; Stone & Webster Engineering Corp.* v. *Ilsley, supra; Standard Oil of California* v. *Agsalud, supra;* and *Pervel Industries* v. *Connecticut Commission on Human Rights and Opportunities.*

† *Metropolitan Life Insurance Co.* v. *Massachusetts, supra; Shaw* v. *Delta Air Lines, Inc., supra; Stone & Webster Engineering Corp.* v. *Ilsley, supra; Standard Oil of California* v. *Agsalud, supra;* and *Pervel Industries* v. *Connecticut Commission on Human Rights, supra.*

§ 1144(a), because its price control identity is merely a "[dis]guise" (*id.* at 14, 19) for its true purpose or effect (*id.* at 12, 24 n. 19), regulating the "form" of covered plans. *Id.* at 9 ¶1.* See also Local 338 *amicus curiae* brief at 7, 10-11. According to the petition (at 12), "form," *i.e.* whether benefits are provided through self-insurance or the purchase of insurance, is indirectly determined by § 2807-a (6), because the statute prohibits hospitals from negotiating discount charges with plans, a claimed "dis-incentive" to self-insurance, and grants non-profit health insurers twelve to fifteen percent differentials, *i.e.*, discounts from equal charges, a claimed 'incentive' to purchasing their insurance. *Id.* at 12 & n. 10.** See also local 338 *amicus curiae* brief at 10-11.

On examination, the petition's claim that PHL § 2807-a (6) is preempted by ERISA § 514(a), 29 U.S.C. § 1144(a), because of its supposed effect on plan "form," amounts to no more than a restatement of the claim, already shown insufficient, that § 514(a) preempts § 2807-a(6) because the state law may reduce benefits by increasing inpatient services prices. See pp. 21-22, 24-26. As established earlier (pp. 21-23), the ERISA and NYPHRM fields of regulation are determined by the content of affirmative legislation and the discretion to make decisions on given subjects. Cov-

* The only purpose of PHL § 2807-a(6) disclosed by the record is its NYPHRM purpose. With state-established or approved rates, § 2807-a(6) implements the inpatient income needs of hospitals, as determined by their NYPHRM revenue caps, and equitably apportions that cost. See pp. 2-10.

** The supposed prohibition/dis-incentive for self-insurance the petition asserts assumes that there is only one reason or, at least, one economic reasor, *i.e.* negotiation of charges, an ERISA-covered plan would decide to self-insure. However, according to the United Optical plan's own agent, there are at least four other economic reasons for plans to self-insure. See p. 11 n.**. See also p. 4 n.**, showing that differentials for non-profit health insurers are justified, and p. 25 n.** ¶2, showing that the supposed "dis-incentive" for self-insurance the petition (at 12 & n.10) attributes to New York and the supposed incentive for self-insurance it attributes to Massachusetts (*Ibid.*) are not present in fact.

ered plans decide whether to self-insure or not, placing that subject, like the subject of the plan benefits, within ERISA's field of regulation. See ERISA § 3(1), 29 U.S.C. § 1002(1) and p. 10. NYPHRM, through state-established or approved rates and the § 2807-a(6) equal charges requirement, decides the price of inpatient services. NYPHRM does not decide plan "form" any more than it decides plan benefits, *i.e.* it has no regulatory authority over the subject, the *sine qua non* for ERISA preemption of a state law under § 514(a), 29 U.S.C. § 1144(a). See pp. 21-23.* The proof that NYPHRM is without authority over plan "form," either under § 2807-a(6) or any other state law, is that only plans can decide their form, and no state agency can compel them to make particular choices. See pp. 21-23 esp. 23 n.*.

The Local 338 *amicus curiae* brief (at 8-10) adopts the petition's contention that PHL § 2807-a(6) regulates plan "form" and takes it one step further, distancing the statute even more from its actual purpose (see pp. 2-10, 28 n.*), and from preemption under ERISA § 514(a), 29 U.S.C. § 1144(a). According to the *amicus* (at 8-10), § 2807-a(6) has two "hidden agendas," both alleged to subject the statute to preemption under § 514(a). First, the *amicus*, like the petition, claims that § 2807-a(6) forces covered plans to abandon self-insurance and to purchase health insurance. Second, the *amicus* claims that § 2807-a(6) mandates benefits for covered plans because the health insurance policies the plans will have to buy have mandatory minimum coverage required by the New York Insurance Law.

The theory offered by the *amicus* proves too much even if its without record basis and dependence on an uncertain chain of causation are put aside. If, in fact,

* Of course, a state law that "indirectly" regulates plan "form" could be challenged under ERISA § 514(a), 29 U.S.C. § 1144(a). *See Alessi* v. *Raybestos-Manhattan, Inc.*, 451 U.S. 504, 525 (1981). However, indirect regulation does not mean inferential regulation. The state law would have to control the subject as *Alessi* demonstrates, since the law there preempted, eliminated one method of calculating pensions. Neither NYPHRM, PHL § 2807-a(6) nor any other state controls, *i.e.* decides, plan "form."

PHL § 2807-a(6) required covered plans to abandon self-insurance, which it does not (see pp. 27-29), the statute would be preempted by ERISA § 514(a), 29 U.S.C. § 1144 (a), at step one of the *amicus'* theory, and step two would not be reached. If § 2807-a(6) were not preempted at step one, as it is not, it would not be preempted at step two because the plans' purchase of the policies would be voluntary action, not the result of state law. Perhaps most critically, if state laws mandating minimum coverage in health insurance policies are subject to preemption under §514(a) when covered plans buy the policies, the New York Insurance Law is in issue, not § 2807-a(6), the only state law the petition (at i, 49a-50a) claims is involved. Conversely, if state laws mandating minimum coverage in health insurance policies that plans buy are not subject to preemption under § 514(a), § 2807-a(6) cannot be subject to preemption either since, on the *amicus'* theory, the statute does no more than allow plans access to policies whose state-regulated terms are free of preemption under § 514(a).

Conclusion

For the Foregoing Reasons, the Petition for a Writ of Certiorari Should Be Denied.

Respectfully submitted,

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